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CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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CHAPTER IV COVERED SERVICES AND LIMITATIONS

INTRODUCTION

The Commonwealth of Virginia offers the following home- and- community- based waivers under the Medical Assistance Program:

Commonwealth Coordinated Care (CCC Plus) Waiver;
Family and Individual Supports (FIS) Waiver;
Building Independence (BI); and
Community Living (CL) Waiver

These waivers differ according to the populations they serve, the medical and functional criteria for eligibility, the long-term services and supports screening (LTSS Screening) process, and the services offered. Under no circumstances can an individual be enrolled in and receive services under more than one home- and community-based waiver during the same time period. However, individuals may be on a waiver and on a waiting list for another waiver at the same time if they meet criteria for both waivers.

The Medallion 4.0 managed care program focuses on providing high quality care for the Commonwealth's pregnant moms, children, and adults. The Medallion 4.0 Program covers new populations and FAMIS populations. Covered populations also include individuals with Third Party Liability (TPL) and those who receive Early Intervention (EI) Services.

The following link is to the Virginia State Law Portal where the Virginia Administrative Code (VAC) State Regulations are listed at: <https://law.lis.virginia.gov/admincode/title12/agency30/>.

Providers are responsible for knowing all of the regulations applicable to the programs and services they provide. This provider manual is a guidance document for services offered under the CCC Plus Waiver. It is written for the fee for service (FFS) providers. MCO health plans are expected to offer what is outlined in this manual; however, they may also choose to offer more services or benefits.

COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) WAIVER

The Department of Medical Assistance Services (DMAS) provides reimbursement for the services provided in the Commonwealth Coordinated Care Plus (CCC Plus) Waiver, which offers individuals an alternative to nursing facility placement. These services include: personal care

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(agency and consumer-directed), respite (agency and consumer-directed) or skilled respite (agency directed), Adult Day Health Care (ADHC), Personal Emergency Response Systems (PERS) which may include medication monitoring, private duty nursing (PDN), assistive technology (AT), environmental modifications (EM), and transition services (for those individuals meeting criteria who are transitioning back to the community from a Nursing Facility, Specialized Care Facility or Long Stay Hospital).

The LTSS Screening Team (Community or Hospital screeners) must determine if the individual is eligible for CCC Plus Waiver services. DMAS or its service authorization (srv auth) contractor must authorize all waiver services in order for any provider, including consumer-directed attendants, to be reimbursed. Individuals may be authorized to receive services based on the documented need for the service(s) and the individual's choice of services and providers. For individuals participating in the CCC Plus program, the chosen Managed Care Organization (MCO) will provide srv auth functions.

SCREENING PROCEDURES FOR CCC PLUS WAIVER SERVICES

The LTSS Screening Team must have explored the individual's functional, medical, and nursing needs. If the individual is at risk of institutionalization within 30 days, the screeners must have also analyzed the specific service needs of the individual, and evaluated whether a service or combination of existing services is available to meet these needs. The LTSS Screening Team must educate individuals and their family/caregiver on alternative settings and services to provide the required care before making a referral for CCC Plus Waiver services. Refer to the Screening Provider Manual for Long Term Services and Supports (LTSS) available on the Medicaid web portal located at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>. The VAC Screening Regulations can be found on the Virginia State Law Portal located at: <https://law.lis.virginia.gov/admincode/title12/agency30/> (12 VAC 30-60-301 through 12 VAC 30-60-315).

Federal regulations governing Medicaid coverage of home- and community-based services in an approved waiver specify that services must only be provided to individuals who have a need for the level of care provided in the alternative institutional placement when there is a reasonable indication that an individual might need the services unless he or she receives home- or community-based services. Under the CCC Plus Waiver, services may be furnished only to individuals:

1. Who meet the nursing facility criteria as outlined in the Medicaid Long Term Services and Supports (LTSS) Screening Manual;
2. Who are eligible for Medicaid;
3. For whom an appropriate, cost-effective Plan of Care can be established, including a viable back-up plan;

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4. Who are not residents of nursing facilities (licensed by the Virginia Department of Health), or assisted living facilities (licensed by DSS) that serve 5 or more individuals;
5. When there are no other or insufficient community resources to meet the individuals' needs; and
6. Whose health, safety, and welfare in the home environment can be ensured.

CCC Plus Waiver services must be the critical services that enable the individual to remain at home rather than being placed in a nursing facility.

AUTHORIZATION FOR MEDICAID PAYMENT OF CCC PLUS WAIVER SERVICES

Screening by the LTSS Screening Team and authorization of CCC Plus Waiver services by the service authorization contractor is mandatory before Medicaid will reimburse for CCC Plus Waiver services.

Medicaid will not reimburse for any CCC Plus Waiver services delivered prior to the authorization date of the physician's signature on the DMAS-96. The date of this authorization cannot be made prior to the date on which the screening assessment is completed and the LTSS Screening Team makes a decision and signs the completed screening.

Reimbursement for CCC Plus Waiver services can only be made when there is a valid, approved service authorization that states the individual, specific service and units, dates of service, and the provider/services facilitator (SF). For more information regarding service authorization requirements, please refer to Appendix D of this manual.

DETERMINATION OF MEDICAID ELIGIBILITY

Every individual who applies for Medicaid-funded long-term services and supports must have his or her Medicaid eligibility evaluated, or re-evaluated, if already Medicaid eligible, by the local department of social services (LDSS) in the city or county in which he/she resides.

Medicaid will pay for CCC Plus Waiver services only after the LDSS has determined that the individual is eligible for medical assistance for the dates services are to be provided. For questions about eligibility criteria or an individual's eligibility status, contact the local LDSS eligibility worker.

MEDICAID APPLICATION PENDING

DMAS cannot reimburse for CCC Plus Waiver services unless:

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1. The screening has been completed by the LTSS Community Screening Team or hospital screener with a determination that the individual meets CCC Plus waiver criteria and waiver services are appropriate;
2. The authorization of CCC Plus Waiver services by the service authorization contractor has been completed;
3. The individual is Medicaid-eligible on the dates that services are rendered; and
4. The individual receives services that are covered under the CCC Plus Waiver as defined by DMAS.

There may be cases in which the individual has been assessed through the LTSS screening process and determined eligible for the CCC Plus Waiver, but Medicaid financial eligibility has not been determined/re-determined. In these cases, the provider/SF/consumer directed attendant may choose to provide services, while awaiting the financial eligibility decision by the LDSS regarding Medicaid financial eligibility, but does so without a guarantee of payment from DMAS. The provider/SF/attendant cannot bill for services provided until the provider/SF verifies that Medicaid has been approved for waiver services via a review either through the Medicaid system or the Automated Response System (ARS) verification through the Medicaid web portal and service authorization has been obtained for the service, units, and dates of service.

In some instances, the provider/SF may accept a referral when the individual's Medicaid eligibility is in a pended status. In these instances, the provider/SF must continue to hold the enrollment package until obtaining a valid Medicaid number. If there is difficulty confirming the individual's eligibility status, contact the eligibility worker's supervisor in the LDSS and, if that person is unable to resolve the questions, contact the regional eligibility specialist. Information on regional offices can be found at the following Virginia Department of Social Services site: http://www.dss.virginia.gov/division/regional_offices/index.cgi.

The service authorization request must be submitted to the srv auth contractor within 10-business days of the receipt of verification of Medicaid eligibility in order for services to be authorized retroactively to the start of care date. No payment will be made for services until Medicaid eligibility is established and authorization has been obtained from the srv auth contractor.

No correspondence or invoices should be included with the enrollment or services requests other than the required forms and documentation as specified in Appendix D of this manual, and the Service Authorization Contractor's website. The srv auth contractor will ensure that level of care criteria and the appropriateness of CCC Plus Waiver services have been met. Any enrollment or service authorization request which is incomplete or submitted incorrectly will be pended by the srv auth contractor, and the provider/SF will be notified. The information must be submitted

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within the timeframe given on the request for additional information notice or the request may be rejected, denied, or partially approved.

A computer-generated letter from the Medicaid Management Information System (MMIS) will be sent to the provider/SF and waiver individual confirming the authorized service, dates and units. For Consumer Directed (CD) services, the Fiscal/Employer Agent (F/EA) receives the authorization information when the letter is generated. Claims and CD timesheets may be paid at this time for services rendered.

LONG TERM CARE COMMUNICATION FORM (DMAS-225)

The LTC Communication Form (DMAS-225) is used by the LDSS to inform providers of Medicaid eligibility and to exchange information.

Immediately upon initiation of services, the provider/SF must send a DMAS-225 to the eligibility unit of the appropriate local LDSS indicating the provider/SF's first date of service delivery. The LDSS eligibility worker will complete an eligibility determination and notify the individual confirming the date the individual's Medicaid eligibility is effective, provide the Medicaid identification number and will notify the provider via the DMAS-225 of the outcome of the eligibility determination. The provider will be given the begin date of eligibility and the Medicaid identification number for the individual. A copy of this completed DMAS-225 must be kept by the provider/SF in the individual's record. The provider/SF must ensure that a completed DMAS-225 has been received from LDSS and is on file in the individual's record prior to billing for services rendered.

The personal/respite care agency, Adult Day Health Care (ADHC), or SF with the most authorized hours must forward a copy of the DMAS-225 form to all service providers when obtained. All providers must notify each other of any change, including discontinuation of services that occurs in the provision of services via the DMAS-225. When multiple providers are involved in the individual's care, the providers must coordinate the DMAS-225 process. A respite provider is responsible for the DMAS-225 only if respite is the sole service provided.

The provider/SF must notify the LDSS via the discharge DMAS-225 and the srv auth contractor electronically via Atrezzo Connect of the provider's/SF's last date-of-service delivery when any of the following circumstances occurs:

- An individual dies - include the date of death;
- An individual is discharged or discontinued from services - The date of discharge or discontinuation should be the last date services were rendered for that individual. This includes when the individual is discharged from one provider agency/SF and admitted to

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another; is admitted to a nursing facility or inpatient rehabilitation hospital (even for one day); or transfers from the CCC Plus waiver to another HCBS waiver or PACE; or

- Any other circumstances that cause services to cease or become interrupted for more than thirty (30) consecutive calendar days. Refer to the *Medicaid LTSS Screening Provider Manual* for more information on requirements for updated and new screenings.

The provider/SF must notify DMAS at: LOCreview@dmass.virginia.gov and request a level of care review when an individual no longer meets criteria for the services or the level of care is in question. For providers working with the MCOs, refer to the Broadcast DMAS-31 notification for more information related to DMAS-225 process. The DMAS-31 notification is posted on the DMAS site under the Eligibility Section.

PATIENT PAY AMOUNT

Patient pay refers to the individual's obligation to pay towards the cost of long-term care services and supports, if the individual's income exceeds certain thresholds. The patient pay amount is determined by the LDSS. The LDSS calculates the monthly patient pay in the Virginia Case Management System (VaCMS) and notifies the individual of the amount. VaCMS transmits the patient pay amount to the MMIS. A patient pay determination is initiated when the provider notifies the LDSS via the Medicaid LTC Communication form (DMAS-225) that an individual on Medicaid has been approved for long-term care services or supports. Whenever there has been a change in the individual's income or circumstances the individual's patient pay amount must be re-evaluated.

The monthly patient pay amount is available to providers through multiple methods: the Automated Response System (ARS), the Virginia Medicaid Web Portal, Medicaid and an electronic Health Care Eligibility Benefit Inquiry and Response transaction (270/271).

Patient pay is tracked monthly as claims are processed and deducted from each claim for long-term care services and supports included in the patient pay processing on a first in (date of adjudication) first out basis until fully deducted. These claims will post edit EOB 1750 (Patient Pay Processing Logic Applied). Patient pay will not be dedicated to a specific provider. Patient pay may be deducted from multiple providers for individuals receiving more than one service included in the automated patient pay processing in the month.

Providers must submit claims for all services, even if the provider does not expect reimbursement for a claim due to patient pay. MMIS is only able to track patient pay when a claim is submitted. Providers are responsible for collecting only the amount of patient pay that is deducted from their claim.

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Providers can use the patient pay in the MMIS as the initial basis for requesting payment from individuals but should be prepared to refund any excess amount collected to reconcile to the amount deducted from claims. This can happen when more than one provider bills for services furnished in a month.

Providers must send in the Medicaid LTC Communication form (DMAS-225) on a timely basis so that the LDSS can update patient pay in the VACMS/MMIS before new claims are processed. Providers should follow up with the LDSS if patient pay has not been updated in 30 days and escalate it to a supervisor if patient pay has not been updated in 45 days. Providers should contact the DMAS Provider HELPLINE if patient pay has not been updated in 60 days.

If patient pay is updated after claims are processed, those claims will not automatically be reprocessed. DMAS will receive a discrepancy report at the beginning of each month listing the paid claims associated with retroactive patient pay changes made during the prior month. DMAS will make manual adjustments for those claims using adjustment reason 1026 (Patient Payment Amount Changed). Depending on the volume, adjustments will be made within 30-60 days after receipt of the discrepancy report. Providers are to contact the DMAS HELPLINE if an adjustment is not made within this time frame.

Agency providers need to document how the actual patient pay amount was obtained. The Fiscal/Employer Agent (F/EA) is responsible for ensuring the patient pay amount is withheld from CD reimbursement.

Patient Pay Collection for Consumer Direction (CD)

The only exception to application of patient pay rules stated above is for those choosing to self-direct (consumer direct) their personal care services. When consumer-directed personal care services are authorized, the Fiscal Employer Agent will be responsible for deducting patient pay from any payments made for consumer-directed services. In this situation, patient pay will not be deducted from other claims paid through the MMIS.

Patient Pay when Respite Care is the Sole Service

Respite care providers are only responsible for collecting the patient pay when respite care is the sole service authorized.

NURSING FACILITY OR INPATIENT REHABILITATION HOSPITAL ADMISSION

When a CCC Plus Waiver individual is admitted to a Nursing Facility (NF) or an Inpatient Rehabilitation Hospital, the waiver enrollment and service authorizations are automatically terminated. Upon discharge, the waiver provider/SF must submit an enrollment DMAS-225 to the

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LDSS, perform a new assessment, plan of care, etc. and request a new service authorization for services. Failure to request a new service authorization will result in non-payment to the waiver provider/SF/attendant until such time as all documentation requirements are met and a service authorization has been approved. Requests for readmission must be submitted within the same timeframes as new requests. If a service authorization is not approved for all dates of service or units, providers/SFs/attendants will not be reimbursed by DMAS for denied dates/units.

HOSPITALIZATION OF INDIVIDUALS

When an individual is hospitalized, the provider should contact the hospital discharge planner or hospital case management department to facilitate discharge planning. Information regarding transfers or plans for admission to a Nursing Facility or Inpatient Rehabilitation Hospital can be obtained through discussions with the hospital discharge planner. If the individual will not be returning to community-based services, the provider must discontinue services and send a DMAS-225 to the LDSS and a discharge request to the srv auth contractor that indicates the individual's last date of service with the provider.

If the individual or family member requests an increase in personal care hours following a hospitalization, the RN/SF must make a post-hospitalization visit to the individual's home and assess the need for the increase. The srv auth contractor will not approve an increase in hours until the individual is discharged home and the RN/SF has made the post hospital assessment visit.

AGENCY-DIRECTED (AD) AND CONSUMER-DIRECTED (CD) MODELS OF SERVICE

Individuals may receive Personal Care, ADHC, Respite (skilled and non-skilled), PDN and Personal Emergency Response System (PERS) through an agency-directed model of care. Individuals may also receive Personal Care and Non-skilled Respite through a consumer-directed model of care. The choice of the model of care is made freely by the individual or the caregiver, if the individual is not able to make a choice.

Medicaid payment is available only for services provided when: the individual is present, in accordance with an approved Plan of Care, the services are authorized, and a qualified provider is providing the services to the individual. DMAS will not pay for services rendered to or for the convenience of other members of the household (e.g., cleaning rooms, cooking meals, washing dishes or doing laundry etc. for the family).

An individual may receive CD services along with AD services. For example, an individual receiving CD personal care services can also receive ADHC or agency-directed personal care. However, individuals cannot simultaneously (same billable hours) receive multiple/duplicative

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services. Simultaneous billing of personal care and respite care services is not permitted. For both AD and CD care, the individual must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the individual, etc.) in case the personal care aide/attendant is unable to work as expected or terminates employment without prior notice. This is the responsibility of the individual and family and must be identified and documented on the Plan of Care. Individuals who do not have viable back-up plans are not eligible for waiver services until viable back-up plans have been developed.

For AD care, the provider must make a reasonable attempt to send a substitute aide; however, if this is not possible, the individual must have someone available to perform the services needed.

Response to Referral: All Services

The provider/SF shall not begin services for which they expect Medicaid payment until the screening packet is received from the LTSS Screening Team and not before the date authorized by the physician's signature on the DMAS-96. The provider must ensure the receipt of a complete and correct LTSS screening packet prior to starting care.

Individuals who are already receiving a CCC Plus Waiver service and have a need to receive an additional service must have this additional service authorized through the srv auth contractor. The provider shall not begin services prior to the date on the MMIS generated letter authorizing the additional service.

The provider/SF must determine, prior to accepting the referral from the LTSS Screening Team, whether they can adequately provide services to the individual. No referral shall be accepted unless the provider/SF has the staff to provide services, and the individual being referred appears appropriate for the provider's/SFs services. However, there may be instances where the provider/SF is unaware of a problem that will prohibit service delivery until the assessment is completed.

Response to Inappropriate Referral for Services

The provider/SF should not initiate services if any one of the following is determined during the initial assessment:

- The individual is not appropriate for CCC Plus Waiver services due to health, safety, or welfare concerns;
- The provider cannot meet the individual's care needs; or
- An appropriate Plan of Care cannot be developed to meet the individual's needs.

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If the provider/SF determines that services should not be initiated, the provider/SF must send a denial letter to the individual which includes appeal rights and notify the eligibility worker at LDSS of this decision immediately. The individual will have 30 calendar days to appeal the decision.

If the provider does not initiate care because of the provider's inability to staff the case adequately, the provider must assist the individual with locating another provider. If there is no provider available in the community that is available to staff the case, the provider must inform the individual of this in writing. Providers should explore the possibility of ADHC, CD services, or AD services as an alternative service. If the lack of services creates a concern about the health, safety, or welfare of the individual, Adult Protective Services/Child Protective Services must be notified.

PERSONAL CARE SERVICES: AGENCY AND CONSUMER DIRECTED

Personal care services means a range of support services necessary to enable the individual to remain at or return home rather than enter a nursing facility or Long Stay Hospital and which includes assistance with (activities of daily living) (ADLs), and instrumental activities of daily living, (IADLs) access to the community, self-administration of medication, or other medical needs, supervision, and the monitoring of health status and physical condition.

Personal care services shall be provided by aides, within the scope of their licenses/certificates, as appropriate, under the agency-directed model; or by personal care attendants under the CD model of service delivery. Personal care is available as either agency-directed (AD) or consumer-directed (CD). These services may be provided in home and community settings to enable an individual to maintain the health status and functional skills necessary to live in the community, or to participate in community activities. The individual must require assistance with ADLs in order for personal care services to be authorized.

Agency-Directed Model

Individuals may choose agency directed services and select a personal care agency to provide their services. Once an agency has accepted the referral, services must be initiated by the RN Supervisor.

Initial Assessment Visit

The RN Supervisor must make an initial assessment visit on or before the start of care. An assessment visit must also be made when an individual is re-admitted after discharge from services or upon transfer from another provider. During this visit, the RN Supervisor must conduct and document all of the following activities:

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- Discuss the individual's support needs, preferences and review of the screening documents from the LTSS Screening Team;
- Assessment and completion of the Community-Based Care Individual Assessment Report (DMAS-99);
- The RN will identify, with the individual or family/caregiver, all individual needs to be addressed in the Plan of Care (DMAS 97-A/B) and develop a safe, appropriate Plan of Care that will meet the identified needs of the individual.

Children may receive personal care services under the waiver just as the adults.

- The RN will review the Plan of Care with the individual and/or the individual's family and the aide (if present), to ensure that there is complete understanding of the services that will be provided.
- The DMAS-97A/B must be completed with the individual's name, 12-digit Medicaid number, provider name and identification number, ADL composite score, RN signature, individual's signature and start-of-care date. (This is the date that the personal care aide actually begins providing care, and this date should also be the one used on the DMAS-225).
- Introduction of the aide to be assigned to the individual, if services start the same day. Each regularly assigned aide must be introduced to the individual by the RN Supervisor, or other staff (this may be done by telephone) and oriented to the individual's Plan of Care on or prior to the aide's start of care for that individual. The RN/LPN Supervisor must closely monitor every situation when a new aide is assigned to an individual so that any difficulties or questions are dealt with promptly.
- The RN must discuss and determine the appropriate frequency of supervisory visits with the individual/caregiver and document the discussion to include the individual's choice on the DMAS-99. The determination of supervisory visit frequency must be based on the individual's health and safety needs. The minimum frequency of these visits is every 90 calendar days.

The assessment by the RN/LPN Supervisor must be done in the home of the waiver individual. The RN/LPN Supervisor will need to access the surroundings of the individual so that an appropriate Plan of Care can be developed based on the individual's needs in the home where the individual will be receiving the care.

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Follow-up Visit

It is recommended that the RN/LPN return for a follow-up visit within 30 calendar days of the initial visit to assess the individual's needs and to make a determination as to whether the plan of care sufficiently meets the individual's needs. When conducted, this visit must be documented on the DMAS-99. At the conclusion of the visit, the DMAS-99 should be signed by the waiver individual. If the individual is a minor or otherwise unable to sign, the primary caregiver, as identified on the DMAS-99, should sign on behalf of the waiver individual. The paid agency aide is not permitted to sign as the individual or primary caregiver.

RN Supervisory Visits

The RN Supervisor must conduct home visits for the purpose of assessing the LPN Supervisor's performance as well as to assess the on-going needs of the individual and services received. The RN Supervisor must identify any gaps in the LPN's supervisor's ability to function competently and shall provide training as appropriate. The RN Supervisor must also conduct a reassessment of the individual's needs and evaluate the plan of care to ensure the services meets the individual's on-going needs. This visit must be conducted every 90 calendar days and documented in the individual's records.

RN/LPN Supervisory Visits

The RN/LPN Supervisor shall make supervisory visits as often as needed to ensure both quality and appropriateness of services and to supervise personal care aides. The minimum frequency of these visits is every 90 calendar days.

During the RN/LPN Supervisory visit, the RN/LPN must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan. If it does not, then a new DMAS 97 A/B must be developed and if a change in the amount of hours is needed, the RN/LPN must submit the request to the srv auth contractor for review. Supporting documentation must be included for hours over the Level of Care (LOC) cap.

A RN/LPN Supervisor must be available to the aides by telephone at all times that an aide is providing services to an individual. A provider may contract with a RN to provide this service. Ongoing assessment of the aide's performance by the RN/LPN Supervisor is also expected to ensure the health, safety, and welfare of the individual.

If the supervising RN/LPN is unable to conduct the regular supervisory visit within required timeframes, it shall be documented in the waiver individual's record with the reasons for the delay. Such supervisory visits shall be conducted within 15 calendar days of the waiver

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individual's first availability.

Based on continuing evaluations of the aide's performance and the individual's needs, the RN/LPN Supervisor shall identify any gaps in the aide's ability to function competently and shall provide training as necessary. The RN/LPN Supervisor must also perform any subsequent evaluations or changes to the supporting documentation.

Consumer-Directed (CD) Model

Individuals choosing to receive services through the CD model may do so by choosing a SF to provide the training and guidance needed to be an employer. As the employer, the individual is responsible for hiring, training, supervising, and firing attendants. The individual may choose to designate a person to serve as the employer on his/her behalf. The individual or the chosen designee is the Employer of Record (EOR). If the individual is under 18 years of age the parent or responsible adult must serve as the EOR. A person serving as the EOR cannot be the paid caregiver, attendant, or SF. An EOR can only serve on behalf of one individual. The only exception to this is that EORs can serve on behalf of multiple individuals only if the individuals reside at the same address.

Individuals have the right to choose, hire, and employ an attendant whom they know has been convicted of a crime that is not prohibited in the applicable sections of the Code of Virginia (32.1-162.9:1), as may be amended from time to time. When doing so, individuals and family members/caregivers must understand this decision and that the consequences thereof are their sole responsibility. The Individual/Employer Acceptance of Responsibility for Employment form must be completed and submitted to the F/EA.

All CD services must be authorized by the srv auth contractor and require the services of a SF.

Specific duties of the individual or EOR, as the employer of the CD personal care attendant, include checking references, determining that the employee meets basic qualifications, submitting required hiring documentation to the fiscal employer agent (F/EA), training, supervising performance, and submitting time sheets to the F/EA on a consistent and timely basis. CD attendants are not eligible for Worker's Compensation.

Service Facilitation H2000 Comprehensive Visit: The SF initiates services with the individual upon accepting the referral of service from the LTSS Screening Team. The SF must make an initial comprehensive home visit prior to the start of care by an attendant. During the visit, the SF will work with the individual or family/caregiver to identify all support needs of the individual to be addressed in the Plan of Care. Based on the information discussed and together with the individual or family/caregiver the SF will develop a safe, appropriate Plan of Care that will meet the identified needs of the individual. The initial comprehensive visit is done only once upon the

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individual's entry into the service. If an individual changes SFs or the individual subsequently adds another CD service, the new provider must conduct and bill for a reassessment visit in lieu of a comprehensive visit.

The initial assessment by the SF, whether a comprehensive or reassessment visit, must be done in the home of the waiver individual. The SF will need to access the surroundings of the individual so that an appropriate Plan of Care can be developed based on the individual's needs in the home where the individual will be receiving the care.

Consumer (Individual) Training (S5109): The SF, using the Employer of Record Manual must provide the individual/EOR with training on the responsibilities as an employer within seven days of the completion of the comprehensive visit (SFs may complete the comprehensive visit and individual training in the same day, if appropriate). To assure that the training content for Employee Management Training meets the acceptable requirements, the SF must use the DMAS CD EOR Manual found on the DMAS website at www.dmas.virginia.gov. The SF must also follow the checklist outlined in the Consumer-Directed Individual Comprehensive Training Form (DMAS-488). This is an outline of the subjects that DMAS requires the SF to cover during the training. The SF must check each subject on the form after it has been covered, and obtain the required signatures and dates. This form must be maintained in the individual's record and be available for review by DMAS staff or DMAS contracted entity. The SF will ensure that the individual/EOR understands his/her rights and responsibilities in the program and signs all of the Participation Agreements including the DMAS-486 and DMAS-489. These forms must be signed before the individual can begin employing an attendant in the program, and a copy of these forms should be kept in the individual's file. The SF should also provide assistance in filling out employer forms in the Employer of Record Welcome Packet that is received from the F/EA.

NOTE: This training is for the employer of the attendant. The SF must not offer training of any type to the attendant.

The consumer training visit (S5109) is only performed once per EOR. If the individual changes EOR, that EOR, so long as the person is not or has not previously fulfilled that role, is required to receive a consumer training visit in order to learn his/her responsibilities as the EOR. Services facilitators should bill for management training (S5116) when an EOR that has received a consumer training visit needs additional training.

If the consumer training takes longer than one visit during that seven-day period, the services facilitator will only submit for one consumer training visit upon completion of all items on the checklist with signatures and dates.

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Routine On-site Visits (99509): After the comprehensive visit, it is recommended that the SF conduct two in-home routine visits within 60 calendar days of the comprehensive visit (once every 30 calendar days), to monitor the individual/EOR's ability to hire and maintain attendants, to monitor the individual's Plan of Care and assess both the quality and appropriateness of the services being provided.

After the first two routine in-home visits, the SF and individual can decide how frequent the routine on-site visits will be based on the individual's needs and documented in the record; however, a face-to-face meeting with the individual must be conducted at least every 90 days for personal care. The frequency of these visits shall be documented on the DMAS-99. For respite care, a face to face meeting with the individual must be conducted every six months, or upon the usage of 240 hours of respite, whichever comes first, when it is provided as a sole service, to ensure appropriateness of services (including reassessments at least every 6- months). The SF must review the individual's status, make any needed adjustments to the plan of care, and provide any necessary information to the individual and record all significant contacts in the individual's record.

If the SF is unable to make a visit due to inclement weather or the individual is not available, the SF must document on a progress note in the individual's record the reason for the delay in the visit and document when the next visit will occur. Such routine on site visits shall be conducted within 15 calendar days of the waiver individual's first availability.

During visits with the individual, the SF must observe, evaluate, and consult with the individual/EOR, family/caregiver as appropriate and document the adequacy and appropriateness of the CD services with regard to the individual's current functioning and cognitive status, medical and social needs, and the established Plan of Care on the DMAS-99. The individual's satisfaction with the type and amount of service must be discussed. The SF must determine if the Plan of Care continues to meet the individual's needs, and document the review of the plan. If it does not, then a new DMAS-97 A/B must be developed and if a change in the amount of hours is needed, the SF must submit the request to the srv auth contractor for review. For hours over the LOC maximum, supporting documentation must be submitted with the service authorization request and the requested hours are not approved retroactive.

The SF must also review copies of the work hours of attendants at least quarterly or more frequently as appropriate to ensure that the hours of service provided are consistent with the Plan of Care. Timesheets may be viewed on the F/EA web portal. If discrepancies are identified in the time sheets in relation to the plan of care, the SF must contact the individual or EOR to resolve discrepancies. If there are consistently discrepancies in the time sheets and training has been offered to the individual/EOR, the SF must meet with the individual/EOR to determine if CD services remain appropriate (i.e., that the individual or EOR can manage the services).

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The SF's documentation of the routine on-site visit must include:

- Whether CD services are adequate to meet the individual's needs and whether changes to the Plan of Care need to be made;
- Any suspected abuse, neglect, or exploitation and to whom it was reported. This must be reported to the Virginia Department of Social Services; Adult Protective Services (APS) or Child Protective services (CPS), as appropriate;
- Hospitalization or change in medical condition, functioning, cognitive status, or social support;
- The individual's or family's /caregiver's (as appropriate) satisfaction with services;
- The presence or absence of the attendant in the home during the visit;
- Any change in who is employed as the attendant. The F/EA cannot pay for any services until a completed packet is received for each employee;
- Dates of and reasons for any service lapses (hospitalization admission, attendant not available, etc.); and
- In addition to the information that must be documented in the SF's routine visit summary, there are several areas (such as bowel/bladder programs, range of motion exercises, catheter and wound care, etc.) that, when they are part of an individual's Plan of Care due to physician's orders, require monitoring by the individual's primary health care professional or a RN and special documentation by the SF of their ongoing completion and the personal care attendant's qualifications to perform these tasks. See this chapter for additional information about the delegation of skilled services.
- A signature from the waiver individual or primary caregiver on the DMAS-99. If the individual is a minor or otherwise unable to sign, the primary caregiver or EOR, as identified on the DMAS-99, should sign on behalf of the waiver individual. The paid attendant is not permitted to sign as the individual or primary caregiver.

Reassessment Visit (T1028): At least every six months for personal care or when respite is the sole service, the SF must meet with the individual or family member/caregiver to conduct a reassessment of the individual's current functional and social support status and a complete summary of all services reviewed. Documentation of the reassessment visit must include a complete review of the individual's needs and available supports and a review of the Plan of Care. The reassessment visit must be documented on a DMAS-99.

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On-going Monitoring Activities: The SF is responsible for counseling an individual/EOR regarding the responsibilities as an employer; requesting from the srv auth contractor any changes of the individual's Plan of Care as needed; consulting with the individual/EOR or family member/caregiver as needed; and discussing with the individual the need for additional community based services. The SF must be available by telephone to individuals receiving CD services during normal business hours, have voice mail capability, and return phone calls within one business day. The SF is not responsible for supervision of personal care attendants and has no authority in hiring/firing attendants. The EOR is solely responsible for attendant supervision.

If the SF determines that the health, safety, or welfare of the individual may be in jeopardy, the SF is responsible for making the appropriate referrals that may include APS/CPS, or if the person is unable to self-direct services a referral to an agency directed service provider may be appropriate.

Management Training (S5116): This training is provided by the SF upon the request of the individual/EOR or to address program rules. This training provided to the individual/EOR is to assist in understanding employer-related activities. Management training is not intended to be needed on-going. Should the EOR need management training consistently, the SF should reassess to determine if the individual is appropriate to serve as the EOR. Management training provided must be documented in the individual's record. Management training must not be used to train the attendant.

Management training can also be used to reimburse the SF for the costs of tuberculosis screening, cardiopulmonary resuscitation certification (CPR), and annual flu immunizations for attendants, as needed. The SF can bill DMAS for the costs of these requirements on behalf of the individual by billing for these costs in management training units and maintaining documentation of these costs in the individual's file.

Verification of Work Hours: The SF shall review attendant hours worked quarterly or more frequently as appropriate to ensure that the hours of service provided are consistent with the Plan of Care. Attendant hours worked may be viewed on the F/EA web portal.

If discrepancies are identified in the work hours in relation to the plan of care, etc., the SF must contact the individual or EOR to resolve discrepancies. Changes in the Plan of Care are warranted if the individual's needs or circumstances have changed. Services provided should be consistent with the Plan of Care. If there are consistently discrepancies in the work hours and training has been offered to the individual/EOR, the SF must meet with the individual/EOR to determine if CD services remain appropriate (i.e., that the individual or EOR can manage the services).

Consumer Directed (CD) Services and Fiscal/Employer Agent (F/EA) Functions

The F/EA performs payroll activities on behalf of the EOR. This allows the individual to use waiver funds to hire and pay attendants. DMAS contracts with the F/EA to ensure that payment

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to the attendant is based on the approved service authorization which documents the number of hours and services and time sheets approved by the EOR. Time worked by attendants is paid based on 15 minute units. The F/EA keeps payment records, and follows all tax rules on the EOR's behalf.

The SF or F/EA will provide a packet of employment information and necessary forms to the individual/EOR. The forms must be completed and returned to the F/EA before the attendant can be employed. The F/EA will handle responsibilities for the individual for paying the attendant and the related employment taxes. The F/EA will process all necessary employer related forms with the Internal Revenue Services (IRS) in order to complete these duties.

Criminal Record and Child Protective Services (CPS) Registry Check: The F/EA performs required criminal record checks for all attendants. When an attendant is providing services to an individual under 18 years of age the F/EA will screen attendants through the DSS CPS Central Registry. See the Employment Packet for more information. The F/EA will provide the individual/EOR with the results of the criminal record request and/or the CPS check and document in the individual's F/EA record that the individual or family member/caregiver has been informed of the results of the criminal record or CPS registry check. If the attendant has been convicted of crimes described in 12 VAC 30-90-180, or if the registry confirms a founded complaint on the attendant, the attendant will no longer be reimbursed under this program for services provided to the individual effective on the date the individual or EOR was notified of the criminal record/CPS registry finding.

Service Units and Limitations

The unit of service for personal care services is one hour. Payment is available only for allowable activities that are authorized and provided by a qualified provider in accordance with an approved Plan of Care when the individual is present. Personal care services are limited to the hours specified in the Plan of Care.

NOTE: There is a 56 hour per week limit for personal care services. For individuals who require more than 56 hours per week of personal care services, specific exception criteria must be met.

Exception Criteria

The following criteria will be applied by providers when seeking an exception to the 56 hour per week limit for personal care services (whether the services are agency directed or consumer directed or a combination of agency and consumer-directed services).

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The waiver individual must have one or more of the following which documents the increase risk of institutionalization:

1. Documentation of dependencies in all of the following activities of daily living: bathing, dressing, transferring, toileting, and eating/feeding, as defined by the current admission screening criteria. (Verification submitted to the srv auth contractor and documented on the questionnaire); OR
2. Documentation of dependencies in both Behavior and Orientation as defined by the current admission screening criteria. (Verification submitted to the srv auth contractor and documented on the questionnaire); OR
3. Documentation from the LDSS that the individual currently has an open case with either Adult Protective Services (APS) or Child Protective Services (CPS) (as described in subdivisions (1) and (2) of this subdivision) and is in need of additional services above the 56 hour per week cap. Documentation can be in the form of a phone log contact or any other documentation provided. (Submitted to the srv auth contractor via attestation.)
 - APS: Is defined as a substantiated APS case with a disposition of needs for protective services and the adult accepts the needed services.
 - CPS: Is defined as being open to CPS investigation if it is either founded OR a completed family assessment documents the case with moderate or high risk.

When submitting attestation information, upon post payment review and/or Quality Management Review (QMR), should documentation regarding proof of attestation submitted to the srv auth contractor is absent in the clinical record, the provider's reimbursement may be subject to retraction and/or a referral to the Medicaid Fraud Control Unit (MFCU) initiated.

Allowable Activities

Allowable activities for personal care tasks that are performed in accordance with the *Virginia Administrative Code 18VAC90-19-240 et.seq. Delegation of Nursing Tasks and Procedures and the Code of Virginia § 54.1-3001(12)* regarding health care tasks directed by the consumer are also allowable. See this chapter for additional information. For services or tasks delegated in accordance with nurse delegation requirements, the RN must be available to the aide/attendant and be able to respond to any complications immediately. Whenever an aide/attendant is performing any physician-ordered procedure, the delegating RN must document on the DMAS-99 or nursing progress note that the aide/attendant's correct performance of the procedure is being observed and supervised by the RN. This must be documented at least quarterly.

The allowable activities for personal care services include the following:

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1. Assistance with activities of daily living (ADLs) such as: bathing or showering, toileting, dressing, transferring, etc.;
2. Assistance with monitoring health status and physical condition;
3. Assistance with self-administration of medication (not to include in any way determining the dosage of medication or the direct administration of medication) and other medical needs;
4. Assistance with preparation and eating of meals, cleaning dishes and eating areas related to the individual's meal (preparation of only the individual's meal is allowed);
5. Assistance with instrumental activities of daily living (IADLs) related to the care needs of the individual such as participant focused housekeeping activities including bed making, dusting, vacuuming, laundry, and grocery shopping, etc., when specified in the individual's Plan of Care and essential to the individual's health or welfare. These activities are limited to those areas that are affected by the individual's direct use and not expected to be performed by the primary caregiver;
6. General support to assure the safety of the individual;
7. Providing routine skin care, such as applying lotion to dry skin, not to include topical medications or any type of product with an "active ingredient";
8. Assistance and support needed by the individual to assure safety and allow the individual to participate in social, recreational, and community activities;
9. Accompanying the individual to appointments or meetings when personal care is needed. For AD services, this must be approved by the agency RN supervisor;
10. Administration of bowel programs by the aide/attendant under special training and supervision, as allowed via nurse delegation or in accordance with the *Code of Virginia. § 54.1-3001(12)*. Certain conditions exist that would contraindicate having the aide/attendant perform a bowel program (i.e., patients prone to dysreflexia such as high level quadriplegics, head and spinal cord injured patients, and some stroke patients). Enemas and laxatives cannot be administered by the aide, even if they are included as part of the bowel program. (Suppositories are an exception to this and can be administered if ordered by the physician as part of a bowel program). Replacement of a colostomy bag as part of the bath is included and may be performed by the aide/attendant. Removal of feces, impacted material, and digital stimulation are not permitted and must be performed by a qualified health professional when these activities are included in the bowel program. The above procedures must only be administered with a physician order;

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11. Administration of range-of-motion (ROM) exercises by the aide/attendant under special training and supervision, as allowed via nurse delegation. For nurse-delegated ROM, a physician must order ROM exercises every six (6) months or more frequently if changes in the individual's condition occurs. This order from the physician must specify that the individual requires ROM and the frequency to be administered. The aide/attendant may perform ROM when he/she has been instructed by the RN Supervisor in the administration of ROM exercises, and the aide/attendant's correct performance of these exercises has been witnessed and documented by the RN Supervisor. This does not include strengthening exercises, resistance exercises, or exercises aimed at retraining muscle groups. The aide/attendant is only permitted to perform those ROM exercises used to maintain current range of motion without encountering resistance. The RN Supervisor will check the ROM on the supervisory visits and will make adjustments to the exercises as often as necessary according to the physician's orders;
12. Wound Care: The aide can perform routine wound care, which does not include sterile treatment or sterile dressings. A physician must order wound care (even routine which does not include sterile technique) every six (6) months or more frequently if changes in the individual's condition occurs. This includes care of a decubitus, which is superficial or does not exceed Stage I. Normal wound care includes washing the area, drying the area, and applying dry dressings as instructed by the RN Supervisor. This does not include the application of any creams, ointments, sprays, powders, or occlusive dressings (such as hydrocolloids and transparencies);
13. Catheter Care: When routine care of a urinary catheter is to be provided by the personal care aide, the RN Supervisor must indicate in the initial RN Supervisor note that the aide is providing catheter care and what instructions the aide has received from the RN Supervisor regarding this care. For condom catheters, the RN Supervisor must observe the initial application of the condom catheter and documentation must indicate the aide's ability to perform this procedure. The same procedure must be followed when substitute aides provide condom catheter care. Instruction by the RN Supervisor must include training of the aide regarding knowledge of the circumstances that require immediate reporting to the RN Supervisor;
14. Checking the temperature, pulse, respiration, and blood pressure with recording and reporting as required;
15. Supervision for those individuals who meet the criteria for Supervision as a component of personal care and whose supervision needs are not otherwise met by formal or informal support systems; and

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16. Home Maintenance Activities: These activities, which are related to the maintenance of the home or preparation of meals, should only be included in the Plan of Care for individuals who do not have an available caregiver. Caregivers living in the home with the individual would be expected to perform housekeeping and cooking activities for themselves and the individual, while completing their own home maintenance activities. However, this should be done on a case-by-case basis taking into account whether the caregiver is able to perform these activities for the individual (and willing to do so, for adult waiver individuals).

For individuals who do not have someone either living in the home or routinely providing assistance, the following activities may be performed for the individual only (not for other members of the family):

- Preparing and serving meals, not to include menu planning for special diets;
- Washing dishes and cleaning the kitchen;
- Making the bed and changing linens;
- Cleaning the individual's bedroom, bathroom, and rooms used primarily by the individual;
- Listing for purchase supplies needed by the individual;
- Shopping for necessary supplies for the individual if no one else is available to perform the service;
- Washing the individual's laundry if no other family member is available or able; and emptying trash in rooms primarily used by the individual, if no other family member is available or able;

DMAS will pay the provider only for services rendered to the waiver individual. DMAS will not pay the provider for services rendered to or for the convenience of other members of the individual's household (e.g., cleaning rooms used equally by all family members, cooking meals for the family, washing family dishes, family laundering, etc.); It is, however, only in very unusual circumstances that a Plan of Care would contain more than two (2) hours per day for housekeeping and meal preparation (combined). These unusual circumstances should be clearly documented on the DMAS-97 A/B and DMAS-99;

17. For CD services, attending training requested by the individual or family member/caregiver that relates to services described in the Plan of Care; and

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18. Social activities: The aide/attendant may accompany the individual to community and social activities to assist the individual with personal care needs or allow the individual the opportunity to participate in these activities. Social time cannot be used for the attendant to sit with or socialize with the individual in the home.

Attending To Personal Care Needs of Individuals During Work or Post-Secondary School

Individuals who receive CCC Plus Waiver services may work and/or attend post-secondary school, while receiving services under this waiver and the personal care aide/attendant may accompany the individual to work/post-secondary school, and may assist the individual with personal care needs while the individual is at work/post-secondary school (i.e. communication needs, toileting, or assistance with eating).

DMAS will not pay for the aide to assist the individual with functions related to the individual completing job/school functions or for supervision time during work or post-secondary school, with the exception of physical assistance provided due to the individual's inability to perform this function due to disability.

The srv auth contractor will review the individual's needs when determining the services that will be provided to the individual in the workplace/post-secondary school. The provider/SF must develop an individualized Plan of Care that addresses the individual's needs at home, work, and/or in the community.

DMAS will not duplicate services that are required as a reasonable accommodation as a part of the Americans with Disabilities Act (ADA) or the Rehabilitation Act of 1973. For example, if the individual's only need is for assistance during lunch, DMAS would not pay for the aide for any time extending beyond lunch. For an individual whose speech is such that they cannot be understood without an interpreter (not translation of a foreign language), or the individual is physically unable to speak or make herself/himself understood even with a communication device, the aide's services may be necessary.

DELEGATION OF SKILLED SERVICES

Personal care and respite services shall not include either practical or professional nursing services as defined in the Nurse Practice Act with the exception of skilled nursing tasks that may be delegated pursuant to the *Virginia Administrative Code 18 VAC 90-20-420 et seq.* The delegating RN is responsible for identifying and assessing if the personal care aide/attendant is capable of performing the skilled nursing activity.

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If the RN delegates this activity to an aide/attendant, the provider/SF must maintain the following documentation:

- The name of the RN, a copy of the RN's current license, and license number, and qualifications as stated in Chapter II of this manual;
- A description of the assessment conducted by the RN that includes the clinical status and stability of the individual's condition;
- The specific tasks that are to be delegated to the aide/attendant;
- A description of the instruction given to the aide/attendant, and confirmation by the RN that the aide/attendant has been witnessed successfully giving the care;
- Review notes by the RN demonstrating the delegated activity is monitored and supervised by the RN at least every 90 calendar days, or more often if determined appropriate; and
- A current physician's order for the service(s). A new physician's order must be obtained every six (6) months or more frequently if changes in the individual's condition occur.

Exemption of Nurse Delegation Requirements

For CD services, the *Code of Virginia § 54.1-3001(12)* states: "any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks" is exempted from the Nurse Practice Act and nurse delegation requirements.

Key requirements for the exemption from nurse delegation requirements:

- Applies to consumer-directed services only
- Applies to tasks that are "typically" self-performed
- The individual receiving service must be capable of directing the attendant in the appropriate performance of the task.
- The individual must live in a private residence
- The individual must be unable to perform the tasks due to a disability

DEVELOPMENT OF THE PLAN OF CARE (DMAS-97A/B): AGENCY- AND CONSUMER-DIRECTED PERSONAL CARE

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The DMAS-97A/B Plan of Care must be completed by the provider/SF at the time of initial evaluation for all individuals. The LTSS Screening documents indicate to the provider/SF the general needs of the individual. The provider/SF should allocate time for the four service categories (which include specific personal/respite care tasks) listed on the DMAS-97A/B. The RN/SF's assessment should note any special considerations for service provision and the support available to the individual. Time does not need to be allocated for each of the tasks on the Plan of Care; these may be checked or a description given, if necessary. Each service category should be totaled if time has been allotted to that category (ADLs, Special Maintenance, Supervision, and IADLs).

Each individual is assigned a level of care based on his/her composite ADL score as calculated on the DMAS-97A/B. The composite ADL score is the sum of a rating of the ADL categories. These categories are bathing, dressing, transfers, ambulation, eating, and continence. The provider/SF must assign a rating for each ADL category that best describes the individual based on the RN/SF's assessment and observation at the time of the initial home evaluation and subsequent reassessments. Once the individual's composite score is derived, a level of care is designated for that individual as a Level A, B, or C. The designation of a level of care determines the **maximum** number of hours per week of personal care services that the individual may have allocated to his/her Plan of Care prior to service authorization. Each level of care category has a **maximum** amount of hours that may be initiated without authorization for that level. The LOC, corresponding composite scores, and **maximum** hours are as follows:

LOC A

(score 0-6)

Maximum Hours prior to service authorization - 25 per week

LOC B

(score 7-12)

Maximum Hours prior to service authorization - 30 per week

LOC C

(score 9+ wounds, tube feedings, etc.)

Maximum Hours prior to service authorization - 35 per week

Prior to designating the level of care, the provider/SF must develop the Plan of Care to reflect the needs of the individual and not necessarily the **maximum amount** of service that the individual is able to have based on the level of care. This **maximum** is based on a seven-day-per-week Plan of Care.

Since the level of care may not reflect the medical needs of the individual based on diagnosis, recent history or the individual's personality or environment, the guidelines may not fully capture

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the range of needs and support that the provider may encounter. It is only in very unusual circumstances that a Plan of Care would contain more than two (2) hours per day for housekeeping and meal preparation (combined). These unusual circumstances must be clearly documented on the DMAS-99 or DMAS-97A/B. The provider is expected to use professional judgment to determine the amount of service needed by the individual. Documentation must support the amount of hours included in the Plan of Care.

The hours requested on the DMAS-97A/B must be the actual time it takes aide/attendant to assist the individual to perform the tasks for the individual. Although the provider/SF may use the **maximum** allowed for the level of care, it is expected that individuals will not routinely require **maximum amounts** of care.

The level of care maximum composite score may not always reflect the range of needs and supports that the individual may need. Service authorization requests must include documentation to support the hours needed.

A copy of the current provider Plan of Care (DMAS 97 A/B) must be kept in the individual's home. The aide/attendant should be instructed to use the provider Plan of Care as a guide for daily service provision.

For AD services the aide should chart tasks performed that are not included in the individual's Plan of Care if the individual has a need for the task to be done. The aide should note why this task was performed. If the need for this task continues to exist, it is then the responsibility of the RN/LPN, who reviews the aide records, to determine whether there is a need for the task to be included on the Plan of Care on an ongoing basis and make the appropriate changes.

Level of Care A - The individual's score is 6 or less on the ADL composite rating. Individuals in Level of Care (LOC) A are the most functionally capable group and, therefore, should usually require the least amount of services (anywhere from 7.5 to 17.5 hours per week). The **maximum amount** of time per week that an individual in LOC A may be provided services has been established at 25 hours per week prior to service authorization. This **maximum** is based on a seven-day-per-week Plan of Care with an average daily need for ADL care of two (2) hours/day and housekeeping of one and one half (1.5) hours per day, when the individual lives alone. Within the level of care, the amount of time required to perform ADL/IADL and housekeeping tasks will vary.

The following guidelines are intended to assist the provider/SF to determine the appropriate allocations of ADL/IADL time for individuals within LOC A.

1. Minimal Needs – Individual is the least dependent, often borderline in meeting the criteria for nursing facility care (ADL score 2-3). The individual may require

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prompting rather than hands-on assistance, may use mechanical help more than human help with a need for standby assistance:

Suggested time allocated for ADLs - .75 - 1 hour/day

Suggested time for Housekeeping - 1 - 1.5 hours/day

2. Average Needs - Individual has somewhat more need for hands-on help, standby assistance, and are somewhat more dependent (ADL score 3-4):

Suggested time allocated for ADLs - 1 - 1.5 hours/day

Suggested time for Housekeeping - 1 - 1.5 hours/day

3. Heavy Needs - Individual will require some help in all areas of ADL care although they will usually be mobile and can probably eat without assistance (ADL score 4-6):

Suggested time allocated for ADLs - 1.5 - 2 hours/day

Suggested time for Housekeeping - 1 - 1.5 hours/day

Level of Care B - The individual's score is between 7-12 on the ADL composite rating. Typically, these individuals will require an average of 15 to 28 hours of service per week. The **maximum amount** of time per week that an individual in LOC B may be provided prior to service authorization is 30 hours per week, with an average daily need for ADL care of 2.5 hours/day and housekeeping of 1.75 hours per day, when the individual lives alone. This **maximum** is based on a seven-day-per-week Plan of Care.

The following guidelines are intended to assist the provider/SF to determine the appropriate allocations of ADL/IADL time for individuals within LOC B. Within this level of care, the amount of time required to perform ADL/IADL and housekeeping will vary. Individuals in LOC B probably require between the heavy time allocated in LOC A and an average amount of time for housekeeping tasks.

1. Minimal Needs - Individual may require assistance to ambulate, but are still able to perform some tasks for themselves (ADL score 7-8):

Suggested time allocated for ADLs - 1.5 - 2 hours/day

Suggested time for Housekeeping - 1 - 1.75 hours/day

2. Average Needs - Individual may require assistance with most ADLs, including transferring, ambulating, eating, and toileting, (ADL score 9-10):

Suggested time allocated for ADLs - 2 - 2.5 hours/day

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Suggested time for Housekeeping - 1 - 1.75 hours/day

3. Heavy Needs - Individual will require the maximum amount of help in all areas of ADL care. They will usually be bed-confined and, therefore, may actually take less time to render services than the individual who performs some self-care but requires assistance (ADL score 11-12):

Suggested time allocated for ADLs - 1.5 - 2.5 hours/day

Suggested time for Housekeeping - 1 - 1.75 hours/day

Level of Care C - The individual's score is 9 or more on the ADL composite rating. Individuals in LOC C are the least functionally capable group and must have skilled medical/nursing needs. Examples of skilled needs are wound care requiring the intervention or observation of a licensed nurse or MD, tube feedings, intravenous infusions, etc. Note: These needs merely qualify an individual to be rated as LOC C. These individuals will probably require an average of from 20 to 30 hours per week. The maximum amount of time per week that an individual in LOC C may be provided prior to service authorization has been established at 35 hours per week, with an average daily need for ADL care of three (3) hours per day and IADL/housekeeping of two (2) hours per day, when the individual lives alone.

The following guidelines are intended to assist the provider/SF with determining the appropriate allocations of ADL/IADL time for individuals within LOC C. Within this level of care, the amount of time required to perform ADL/IADL and housekeeping tasks may vary.

1. Minimal Needs - Individuals may have the **maximum** in-home support and minimal special maintenance needs. Some of the individuals in this minimum range of needs within LOC C will actually be quite dependent, but may be cared for quickly merely because they do not participate in their own care:

Suggested time allocated for ADLs - 1.5 - 2 hours/day

Suggested time for Housekeeping - 1 - 2 hours/day

2. Average Needs - Individuals will generally require more ADL time to prevent skin breakdown by frequent turning, may require wound care, feedings completed by the family, etc., and have only moderate support to assist with this care:

Suggested time allocated for ADLs - 2 - 3 hours/day

Suggested time for Housekeeping - 1 - 2 hours/day

3. Heavy Needs – May be individuals living with complex medical needs or their condition provides constant barriers to performance of ADLs without human help and

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at risk for rapid deterioration if daily supports are not in place.

Suggested time allocated for ADLs - 2 - 3 hours/day

Suggested time for Housekeeping - 1 - 2 hours/day

The **maximum amount** of care established for all levels of care were not established with regard to the need for supervision as a personal care task. Additional time can be added to the Plan of Care beyond the **maximum amount** of time for that individual's level of care, but requires authorization from the srv auth contractor before it can be initiated. The time allocated on the Plan of Care for ADLs, IADLs, Special Maintenance and Supervision shall not be inflated to provide extra personal care time.

Supervision

Personal care services allow for individualized hands on care that is based on the needs of the participant. While individuals may not always require constant ADL supports, there may be a need for the individual to have services authorized during times when they cannot safely be left alone.

Supervision is an allowable activity within the personal care Plan of Care when the purpose is to supervise or monitor those individuals who require and have a documented need for the physical presence of the aide/attendant to ensure their safety during times when no other support system is available. The inclusion of supervision in the Plan of Care is appropriate only in the following situations:

- The individual cannot be left alone **at any time** due to mental or severe physical incapacitation;
- The individual is unable to call for help in case of an emergency and there are no competent adults in the home who are capable of dialing 911 in the event of an emergency; and
- When supervision is deemed necessary to ensure the health, safety, or welfare of the individual.

When members demonstrate a support need that is intermittent in nature, supervision must be considered as an option to provide coverage for participants who are not safe or have health risks that require immediate attention when the member is left alone.

Supervision will not be authorized for family members to sleep either during the day or during the night unless the individual is dependent in orientation and behavior pattern (documented on the DMAS-99) and cannot be left alone at any time due to documented safety issues or wandering risk. Supervision cannot be considered necessary because the individual's family or provider is generally concerned about leaving the individual alone, or would prefer to have someone with the

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individual. There must be a clear and present danger to the health, safety, or welfare of the individual as a result of being left unsupervised.

Supervision as a component of personal care must be authorized prior to being rendered and cannot be authorized retroactively. The effective date of authorization for supervision hours will be no earlier than the date of receipt by the srvc auth contractor, with the exception of provider transfers, as detailed later in this chapter. In no case shall more than eight hours (8) per day of Supervision as a component of personal care be authorized.

In every case in which the provider/SF has identified the need for supervision to be included in the individual's Plan of Care, the following documentation requirements must be met:

- The RN Supervisor/SF must complete a DMAS-100 (Request for Supervision Form).
- The DMAS-100 form must include:
 - the reason supervision is needed,
 - the amount of supervision needed,
 - the schedules of all adult residents in the home and formal and informal caregivers, and
 - must identify who will provide supervision in the absence of the personal care aide. Supervision cannot be authorized prior to the signature/date of completion of this document.

Supervision time must not include time allotted for ADL, Special Maintenance, or IADL care. The supervision component of the Plan of Care does not include assistance needed for ADL's, Special Maintenance or IADL's. Time for these components must be included in the appropriate section of the Plan of Care. Supervision is not intended as additional time to perform these tasks.

If the individual's primary caregiver has a business or works in the home, supervision will be considered if the individual is documented as being dependent in orientation and behavior pattern on the UAI and/or documented on the DMAS-99. Supervision may be needed when the primary caregiver is working in the home and is unable to provide the required supervision because of work requirements.

The amount of supervision time in the Plan of Care must be no more than is necessary to prevent physical deterioration or injury to the individual and ensure health, safety, and welfare needs are met.

If the individual requires more supervision and time beyond that which is provided through the personal care time allowed for ADLs, Special Maintenance, Supervision and IADLs, the individual must have a support system that is willing and able to provide the additional assistance/supervision. Individuals who have supervision time in the Plan of Care must have documentation that someone is with them 24 hours a day.

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If supervision is being requested while the caregiver works, the provider/SF may be asked to submit a note from the caregiver's employer to the srv auth contractor verifying the work schedule.

Personal Emergency Response Systems (PERS) may be an appropriate service for an individual who does not meet all of the requirements for supervision. An individual may not have supervision and PERS simultaneously.

Special Maintenance

Special maintenance is a covered service within the Plan of Care when an individual has an identified need for skilled care that may be performed by an aide/attendant as specified above under Allowable Activities. These tasks may include vital signs and recording of findings, assistance with medications, bowel program, ROM and wound care.

Personal Care Services to More than One Individual in the Same Household

There may be instances in which two or more individuals residing in the same household receives personal care through the same agency or SF. When this occurs, tasks such as meal preparation, cleaning rooms, laundry, and shopping considered as Instrumental Activities of Daily Living (IADL) must be provided for both individuals simultaneously. Each individual will need a Plan of Care with separate ADL hours and shared IADL hours. Should the individuals choose to have separate agencies to provide care or separate SFs, these hours are not shared.

Annual Plan of Care

The provider/SF must either complete a new Plan of Care at least annually or document on the current Plan of Care (DMAS 97A/B) annually that the Plan of Care was reviewed, then date and sign that no changes are necessary. Copies of all Plans of Care must be maintained in the individual's record.

Changes to the Plan of Care

The provider/SF is responsible for making modifications to the Plan of Care as needed to ensure that the aide/attendant and individual/EOR or family/caregiver are aware of the tasks to be performed and that the hours and type of care are appropriate to meet the current needs of the individual. Any time there is a need to change the number of hours for an individual, the provider/SF must develop a new Plan of Care. The most recent Plan of Care must always be in the individual's home and available for the aide/attendant to review prior to delivery of services

The provider/SF is permitted to develop a Plan of Care and subsequently make changes to the Plan of Care without prior approval from the srv auth contractor as long as the individual's amount of service does not exceed the **maximum amount** established for that individual's level of care and

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as long as supervision is not being added as a new service. For changes within the LOC maximum, the provider/SF must submit to the srv auth contractor the change of hours for billing purposes, within the timelines established for submission. Reimbursement for the full amount of services included in the Plan of Care may be denied when the individual's Plan of Care is inflated beyond the actual, documented needs of the individual.

Any hours beyond the maximum for the individual's level of care must be authorized by the DMAS srv auth contractor. DMAS will not reimburse retroactively for hours over the LOC maximum which were provided prior to the date the request was submitted to the srv auth contractor, with the exception of provider transfers, as outlined later in this chapter.

Changes of hours must be submitted to the srv auth contractor. If the hours on the new Plan of Care exceed the individual's current level of care on the DMAS-97A/B, the provider/SF must submit to the srv auth contractor information from the new Plan of Care reflecting the revised hours and updated composite ADL score reflecting the level of care. The srv auth contractor may request Plans of Care, or any supporting documentation at any time. Providers/SFs are required to submit changes in hours when they occur.

The provider/SF must follow the procedures to request a revised service authorization whenever a change in the individual's condition (physical, mental, or social) indicates that:

- The individual requires supervision to be added to the Plan of Care even if the individual's hours will be within the level-of-care category; or
- An increase or decrease in the Plan of Care is needed regardless of whether it is within or outside of the amount allowed according to the level of care, in order to assure appropriate reimbursement for services.

When multiple providers/SF are working with the individual and a change to the Plan of Care is required all providers/SF involved shall consult to coordinate the changes to the Plan of Care. An individual can have only one SF, but there could be one or more agency providers. This applies to changes upon admission of a new individual or after services have been initiated. This communication must be documented in each provider/SF's individual record.

See Appendix D of this manual for information regarding submittal of service authorization requests.

The srv auth contractor will transmit authorizations or denials into the MMIS. Once the entry has been made, the provider/SF and individual will receive a computer-generated letter notifying them of the decision and providing appeal rights if a partial approval or denial is issued. Individuals have the right to appeal any adverse action taken by the srv auth contractor. A copy of this letter

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must be maintained in the individual's record. If a denial is issued, the provider/SF will also be notified via fax by the srv auth contractor.

Personal Care Split-Shift Service Delivery (Agency and Consumer-Directed)

There are situations in which the individual may benefit from services offered during two distinct shifts during the day (i.e., morning and evening). For example, an individual may need assistance with ADLs in the morning and additional ADL assistance in the evening. A split shift is indicated when there are at least two hours between each shift. When a split shift is desired, the provider/SF must complete two Plans of Care, labeled AM and PM, to indicate each shift of services. The total number of hours on morning and afternoon Plans of Care combined cannot exceed the number of hours allowed for the individual's level of care without prior approval from the srv auth contractor.

For agency-directed services, when a split-shift service is provided and a different aide is working on each shift, the RN/LPN Supervisor must alternate the supervisory visit between both shifts in order to provide supervision to each aide. If weekend or night service is the only time when the services are provided (example: 11:00 p.m. until 7:00 a.m.), the RN/LPN must make a supervisory visit at least every other visit during the time the aide is working. If the individual is also receiving services during the day hours, and the aide that is providing the weekend or night services is different than the weekday aide, the RN/LPN can make the supervisory visit during the weekday and discuss the other shifts with the individual and/or family/caregiver.

Scheduled Services Not Provided

The personal care aide/attendant is responsible for following the current Plan of Care (DMAS-97A/B). If the aide/attendant does not work the total number of hours during a scheduled day, as it is listed on the DMAS-97A/B, the aide/attendant may use the unused hours on another day within that same week only if:

1. The individual/EOR and/or primary caregiver requests that the unused time be used on another day of that week; and
2. The reason for the hours to be carried over to another day is for extraordinary circumstances that cannot be accommodated by the Plan of Care, and the leftover time is needed to meet the needs of the individual. For Agency Directed care, the need must be documented by the aide on the Provider Aide Record (DMAS-90) and by the RN/LPN in the individual's record. The reason cannot be to allow the aide/attendant to make up the unused hours of the week; and
3. The total amount of hours worked during the week does not exceed the number of authorized hours for the week as noted on the DMAS-97A/B.

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Inability Of An Aide To Provide Services And Substitution Of Aides- Agency-Directed (AD) Model If a provider cannot supply an aide to render authorized services, the provider may either obtain a substitute aide from another provider, if the lapse in coverage is expected to be less than two weeks in duration, or may transfer the individual's services to another provider. If the provider obtains a substitute aide from another agency, the two providers are responsible for negotiating the financial arrangements of paying the substitute aide.

When a substitute aide is secured from another provider, the following requirements apply:

- The authorized provider is responsible for providing the supervision for the substitute aide;
- Only the authorized provider may bill DMAS for services rendered by the substitute aide;
- The authorized provider must ensure that all DMAS requirements continue to be met; and
- The agency providing the substitute aide must send to the provider having individual care responsibility a copy of the aide's daily records signed by the individual and the substitute aide. All documentation of services rendered by the substitute aide must be in the individual's record. The documentation of the substitute aide's qualifications must also be obtained and recorded in the personnel files of the responsible provider.

Substitute aides obtained from other providers should be used only in cases where no other arrangements can be made for personal care services coverage, and should be used on a temporary basis. If a substitute aide is needed for more than two weeks, the case must be transferred to another provider that has the aide capability to serve the individual(s).

If no other provider can supply an aide, the provider shall notify the individual or family and explain the possible availability of CD services or ADHC. Service authorization is required in those cases in which the services are transferred to another provider, to CD services, or ADHC.

Some waiver individuals take turns staying with different relatives throughout the year in different parts of the state. Rather than transferring a case back and forth, one primary provider (which could be an ADHC or a personal care provider) may contract with a provider in another city or county to provide services. In that event, the same procedure should be followed for obtaining a substitute aide.

Respite Care

Respite services are unskilled services (AD or CD) or skilled services of a nurse. Agency-directed respite can be performed either in the home and community of the individual by a personal care aide or at a licensed Children's Residential Facility for children with a developmental disability

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where multiple staff may provide care during the individual's stay. Respite is for the relief of the **unpaid primary caregiver** due to the physical burden and emotional stress of providing support and care to the waiver individual. The maximum amount of all types of respite care services that an individual may receive is **480 hours** in a state fiscal year (July 1 – June 30).

For AD respite care, the provider agency is responsible for tracking the number of hours used. If the individual is using both AD and CD respite services, the SF and the provider agency must coordinate the tracking of the respite care hours used. Respite care must be authorized by the srv auth contractor before being rendered. If more than 480 hours per state fiscal year are provided, DMAS will only pay for the first 480 hours that are billed.

Individuals who exhaust their maximum amount of hours prior to the end of the authorization period must be informed that no additional hours will be authorized. In these cases, they must wait until the state fiscal year has expired. The provider/SF must ensure that the individual continues to meet the criteria, as stated above, to receive respite services.

An initial Plan of Care (DMAS-97A/B) must be developed by the provider/SF and updated annually.

Note: Respite care can be authorized as a sole waiver service, or it can be offered in conjunction with other services. Medicaid payment is available only for services authorized and provided according to the Plan of Care and provided by a qualified provider.

Skilled Respite Care (Agency-Directed Only)

Providers may be reimbursed for respite services provided by a LPN or an RN with a current, active license and able to practice in the Commonwealth of Virginia as long as the service is ordered by a physician and the provider can document the individual's skilled needs. DMAS will reimburse for LPN respite care for those individuals who require the skilled level of care and who meet the criteria below.

The circumstances that warrant provision of skilled respite care by a LPN or RN are:

- The individual receiving care has a need for routine skilled care that cannot be provided by unlicensed personnel [i.e., individual requiring nasogastric or gastrostomy feedings, injections, wound care etc. that is not or cannot be delegated or provided in accordance with the *Code of Virginia § 54.1-3001(12)*];
- No other individual in the individual's support system is able to provide the skilled component of the individual's care during the caregiver's absence;

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- The individual is unable to receive skilled nursing visits from any other source which could provide the skilled care usually given by the caregiver; and
- A physician's orders for services is obtained for the skilled care, prior to the service begin date and updated every six months. The DMAS-300 or CMS-485 may be used for this purpose.

Under respite care services, a LPN can perform selected nursing procedures under the direction and supervision of a RN. Such selected procedures may include:

- Administration of medications;
- Care of tracheotomies, feeding tubes, etc.; and
- Wound care requiring sterile technique.

When a nurse is required, the nurse must also provide services normally provided by an aide and shall document the tasks performed on the Skilled Respite Record (DMAS-90A). These records are to be kept in the individual's respite record. For skilled respite services, the nurse's skills and knowledge necessary to provide the services must be documented.

If the individual receives skilled respite services, a separate record or a separate section of the individual's record must contain the forms and necessary documents addressing respite services and authorization.

These respite forms include:

- Skilled Respite Record (DMAS-90A) signed and dated by the nurse and the individual or family/caregiver. It must contain weekly notes on the individual's care and status;
- Respite Care Needs Assessment and Plan of Care (DMAS-300) or CMS-485, if respite is the sole service the individual is receiving;
- The RN Supervisor's documentation using the DMAS-99; and
- A physician's order/CMS-485/DMAS-300 for skilled services. The order must specify the skilled services the nurse will render.

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Supervision of Respite: Agency-Directed (AD) Model

The respite care agency shall employ or contract with and directly supervise a RN/LPN who will provide ongoing supervision of respite care aides. A RN shall provide supervision to all direct care LPNs.

When respite care services are received on a routine basis, the minimum acceptable frequency of the required RN/LPN supervisor's visits shall not exceed every 90 calendar days, based on the initial assessment. If an individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN supervisory visits. However, the RN supervisor shall document supervision of respite care separately from the personal care documentation. For this purpose, the same individual record may be used with a separate section for respite care documentation.

When respite care services are not received on a routine basis but are episodic in nature, a RN/LPN supervisor shall not be required to conduct a supervisory visit within a specified number of days. Instead, a RN/LPN supervisor shall conduct the home supervisory visit with the aide/LPN on or before the start of care and make a second home supervisory visit during the second respite care visit. If a waiver individual is also receiving personal care services, the respite care RN/LPN supervisory visit may coincide with the personal care RN/LPN supervisory visit.

When respite/skilled respite services are offered in conjunction with personal care, the supervisory visit conducted for personal care may serve as the supervisory visit for respite. The RN/LPN must document on the DMAS-99 whether respite is being used and the reason why. The RN/LPN supervisor must document on the DMAS-99 that the supervisory visit is for both personal care and respite care. This documentation may be kept in one record but must be maintained with a separate section for respite services documentation. The supervisor must document supervision of respite services separately. If a separate record is used for both personal care and respite care, the DMAS-99 must be in each record. When the supervisory visit is for both personal care and respite, the DMAS-99 form must be used. A copy of the DMAS-99 may be filed in the respite record or section of the chart; however, the original document must be available in the personal care record or section.

When respite care services are received through a licensed Children's Residential Facility, the RN/LPN supervisor should review the Plan of Care prior to each utilization of respite care services. If the individual's status or health condition have changed, the RN/LPN supervisor should update the Plan of Care as necessary with the family/caregiver. The RN/LPN supervisor shall conduct the supervisory visits with the individual and family/caregiver at the Children's Residential Facility. The RN/LPN supervisor will not be required to perform the visit in the home of the individual.

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AGENCY-DIRECTED MODEL OF PERSONAL CARE AND RESPITE SERVICES

Required Documentation for Individual Records for Personal and Respite Care

The provider shall maintain a record for each individual. These records must be separated from those of other services, such as home health services. If an individual receives personal care and respite care services, one record may be maintained, but separate sections must be reserved for the documentation of the two services.

The individual record must include the following documentation:

- If the individual is newly enrolled in the waiver, the LTSS Screening Packet which includes: Uniform Assessment Instrument (UAI); the Screening Authorization signed by all members of the LTSS Screening Team (DMAS-96); the Individual Choice Form (DMAS-97 or DMAS-300 for only Respite Care services);
- All provider Plans of Care (DMAS-97A/B); Supervision Request Form (DMAS-100), if applicable; Community Based Care Individual Assessment Report (DMAS 99); Aide Records (DMAS-90) and all LTC Communication Forms (DMAS-225);
- The initial assessment by the RN must be completed on or before the start of care date on the DMAS-99. This must be filed in the individual's record within two (2) weeks from the date of the visit. Only the DMAS-99 can be used for nursing assessments. The Comprehensive Adult Nursing Assessment form, or OASIS form, is not acceptable;
- All RN/LPN Supervisor notes must be completed and filed within two weeks of the supervisory visit. Any supervisory visit not documented and present in the individual's record will be considered as not having been made;
- The frequency of the RN/LPN Supervisor visit must be conducted within the timeframe that was agreed upon by the individual and/or caregiver and documented by the RN on the DMAS-99;
- The aide must be present during the RN/LPN Supervisor's visit at least every other visit. If the aide is always present during the Supervisory visit, then every other month the RN/LPN must arrange to speak with the individual/family privately to assess the family and individual's satisfaction with services. If it is not possible to arrange a private conversation with the individual and/or family, the RN/LPN must make a telephone call to the family or individual during non-personal care hours. This telephone conversation must be documented in the individual's record. This gives the family or the individual, or both, the ability to address any concerns or issues without the presence of the aide;

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- The RN/LPN Supervisor's documentation, using the DMAS-99, must include the observations of the individual made during the visits as well as any instruction, supervision, or counseling provided to the aide working with the individual. The RN/LPN Supervisor's notes must also clearly document that he/she has discussed with the individual or family member the appropriateness and adequacy of service. Individual/family/caregiver satisfaction with the services should be documented;
- The RN/LPN Supervisor summary must note:
 - Any change in the previously documented individual's medical condition, functional status, and social support. The RN/LPN Supervisor is expected to know the nursing facility criteria and to apply the criteria when assessing whether the individual continues to meet nursing facility criteria to receive personal/respite care services. If the RN/LPN Supervisor determines that the individual does not meet criteria for personal/respite care services, the RN Supervisor must contact DMAS for a level of care review and to discuss discontinuation;
 - Whether the Plan of Care is adequate to meet the individual's needs or if changes need to be made;
 - Dates of any lapse of services and why (e.g., hospitalization, nursing facility or inpatient rehab hospital admission and discharge dates, aide not available, etc.);
 - The presence or absence of the aide in the home during the visit; and
 - Any other services received by the individual;
- All provider contacts with the individual, family members/caregivers, health professionals, formal and informal service providers, the srv auth contractor, DMAS, etc., must be documented. All notes must be filed in the individual's records within two (2) weeks from the date of the contact;
- All DMAS-99 and DMAS 97-A/B forms, signed and fully dated by the RN/LPN;
- All personal care/respite aides' records (DMAS-90);
- Personal/respite services must have an individualized Plan of Care that reflects the results of an assessment completed prior to or on the date services are initiated (and subsequent reassessments annually and as needed) and includes the activities that will be provided during the personal/respite care period and the approximate hours that will be allowed for

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each activity. The Provider Agency Plan of Care Form (DMAS-97A/B) must be used for this purpose;

The provider must copy the questionnaire and any information entered by direct data entry that is submitted electronically via the srv auth contractor's portal system; and

- During visits to the waiver individual's home, the RN/LPN supervisor shall observe, evaluate, and document the adequacy and appropriateness of personal and/or respite care services with regard to the waiver individual's current functioning status and medical and social needs. The aide's/LPN's record shall be reviewed and the waiver individual's or family's/caregiver's, or both, satisfaction with the type and amount of services discussed and documented.

The provider is responsible for documenting the monitoring of the ongoing provision of services to each Medicaid individual. This monitoring documentation includes:

- The quality of care provided by the aide, LPN (when utilized) and the RN;
- The functional and medical needs of the individual and any modification necessary to the Plan of Care due to a change in these needs; and
- The individual's need for support in addition to care provided by personal/respite care aide. This includes an overall assessment of the individual's health, safety and welfare in the home with personal/respite care.

Aide Responsibilities/Required Documentation: Agency-Directed (AD) Model

The aide is responsible for following the Plan of Care, notifying the RN or LPN Supervisor of any change in condition, support, or problem that arises and documenting the performance of duties on the DMAS-90.

The DMAS-90 must be completed on the day the service was delivered. The DMAS-90 is designed to contain one calendar week of service provision. Agencies may not, in any way, make changes to the DMAS-90. If the same aide renders personal care and respite care services to the individual, a separate DMAS-90 must be used for the different services, even if the two services are rendered on the same day.

Documentation on the DMAS-90 must include:

- the specific services delivered to the waiver individual by the aide;

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- the personal care/respite aide's actual daily arrival and departure times;
- the aide's weekly comments or observations about the waiver individual, including the individual's physical and emotional condition, daily activities, and responses to services rendered;
- any other information appropriate and relevant to the waiver individual's care and need for services;
- Signatures: the personal care aide's and individual's or responsible caregiver's weekly signatures, including the date, to verify that personal care services have been rendered during that week as documented in the record. An employee of the provider cannot sign for the individual unless he/she is a family/caregiver of the individual. This family member cannot be the same family member who is providing the service. In instances where the individual is unable to sign and there is no family member or other legal representative to do so, the reason for the absence of this signature must be thoroughly documented on the DMAS-90. If the individual is unable to sign his/her signature on the DMAS-90, the individual may make an "X". The RN Supervisor must document on the DMAS 99 that the "individual is unable to sign the DMAS-90";
- documentation on the DMAS-90 must be in the English language; and
- signatures, times and dates shall not be placed on the personal care aide record prior to the last date that the services are actually delivered. The aide record sheets must be in the individual's record within two (2) weeks.

Corrections to any form in the record must be made by drawing a line through the incorrect entry, then re-enter and initial and date the correct information. Correction fluid ("white-out") must never be used for correction in medical records. Copies of all documents are subject to review by state and federal Medicaid staff or representatives. The records contained in the chart must be current within two (2) weeks at all times of the date of service delivery.

It is the responsibility of the provider to ensure that the DMAS-90 are delivered to the provider and filed in the individual's record within two (2) weeks. A periodic review of the DMAS-90 must be done prior to filing it in the individual's record to ensure that the RN Supervisor is aware of any changes in the individual's needs or any changes in the Plan of Care, which may be indicated by the aide's documentation on the DMAS-90. An accurately signed and dated DMAS-90 is the only authorized documentation of services provided for which DMAS will reimburse. DMAS will not accept employee payroll time sheets in place of the DMAS-90.

When respite care services are performed in a licensed Children's Residential Facility, the start and end times of each aide providing care to the minor waiver individual shall not be required on the DMAS-90. Instead, the start and end times of the waiver individual's stay at the facility should be documented. Each aide that provides care to the waiver individual may attach individual notes to the DMAS-90 with a corresponding signature.

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Electronic Visit Verification (EVV)

Personal care agencies utilizing HIPAA compliant EVV systems may do so by using a system that records and contains the same elements as the DMAS-90 and permits the system to verify the location from which the services are provided and the individual for whom the services are provided.

The EVV shall: 1.) Ensure daily back-up for all data collected; 2.) Protect data securely and reliably; 3.) Demonstrate a disaster recovery mechanism allowing for use within twelve hours of disruption to services (subject to exceptional circumstances such as war and other disasters of national scope); and 4.) Be capable of producing reports of all services and supports rendered, the individual's identity, the start and end time of the provision of services and supports and the date/s of service in summary fashion that constitute documentation of service that is fully compliant with regulation.

The EVV system, at a minimum, must be able to capture the following required data elements:

1. Type of service performed (personal care or respite);
2. Individual receiving the service;
3. Date of the service;
4. Location of the service delivery (beginning and ending);
5. Individual providing the service; and
6. Time the service begins and ends.

Each personal care aide and individual/family receiving services will have a unique personal identification number or a biometric identification system. The personal care aide shall not be able to enter or modify the time and date. The unique identification system shall constitute the necessary electronic signatures for services. No additional electronic or "wet" signatures shall be required.

Adjustments may be allowed when necessary to EVV shifts. Adjustments must be made by an RN, supervisor, agency owner, or other designee who has the authority to make independent verification. Personal care aides are not permitted to adjust their own shifts nor those of other personal care aides. Each manual entry and/or adjustment must include documentation as to why manual entry was performed and why the visit was not electronically verified at the time of service. If there is an ongoing need to perform a manual entry for an individual's shifts, it must be documented on the DMAS-99 with the explanation, such as no cell phone service, GPS, or landline to verify location.

Claims submitted for reimbursement must not exceed the actual time worked based on the EVV data. Agency staff authorized to make edits should not edit clock-in and clock-out times to match the aide's scheduled start and end times.

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Electronic Visit Verification (EVV) and DMAS-90

- record sheets must be in the individual's record within two (2) weeks.

EVV systems that are used in place of the DMAS-90 must contain the same elements and must be consistent with the DMAS-90 requirements starting on page 41. Personal care agencies should verify that their EVV system matches all of the same fields as located on the DMAS-90. Furthermore, the EVV version of the DMAS-90 should not differ from the paper version. Additional tasks or fields not present on the DMAS-90 should not be listed or made available as tasks to mark as completed.

The aide should adhere to the DMAS-97A/B Plan of Care when rendering services and completing a work shift. EVV systems must not systematically require task completion in order for the aide to complete the end of the shift. The aid should only document tasks that were actually completed.. I When the Plan of Care includes a task that the aide does not perform during his/her shift, the EVV system should allow the aide to proceed with leaving the task unchecked. As with a paper DMAS-90, the aide should notate why tasks listed in the Plan of Care were not performed via the electronic DMAS-90.

If the EVV system does not capture or have all of the same fields available to complete, the electronic version does not meet DMAS standards, and the paper DMAS-90 form is required for each service delivery and must be kept in the individual's file.

Attendant Responsibilities/Required Documentation: Consumer-Directed (CD) Model

Documentation must clearly indicate the dates and times of CD personal care services delivery (i.e., shifts submitted to the F/EA contractor). CD attendants may document services on the DMAS-487 (at the discretion of the employer of record, this is optional for CD attendants).

Required Services Facilitation Documentation

The SF must maintain records for each individual served. These records must be separated from those of any other services that may be provided by the SF/SF's employer. All documentation must be filed in the individual's record within two (2) weeks from the date of the visit/contact.

The individual medical record must include the following:

- If the individual is newly enrolled in the waiver, the LTSS Screening Packet which includes: the Uniform Assessment Instrument (UAI); the Pre-Admission Screening Authorization signed by all members of the LTSS Screening Team (DMAS-96); the Individual Choice Form (DMAS-97 or DMAS-300 for Respite Care services, as applicable);

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- All provider Plans of Care (DMAS-97A/B); Supervision Request Form (DMAS-100), if applicable; Community Based Care Individual Assessment Report (DMAS 99);
- All copies of the CD Services Plans of Care (DMAS-97 A/B), the results of the SF's initial comprehensive home visit (or initial reassessment visit) completed on or before the start of care date (and subsequent reassessment visits, as needed) on the DMAS-99. Only the DMAS-99 may be used for assessments/reassessments. The start date on the Plan of Care will be the start date of service facilitation services for the individual;
- The SF must copy the questionnaire and any information entered by direct data entry that is submitted electronically via the srv auth contractor's portal system;
- All DMAS-225 forms;
- All correspondence and SF notes recorded and dated documenting contacts with the individual/EOR and family/caregiver, DMAS, and the srv auth contractor;
- Records of contacts made with physicians, formal and informal service providers, and all professionals concerning the individual;
- All management training provided to the individual/EOR or member/caregiver, including the individual's or family/caregiver's responsibility for the accuracy of the attendant's time sheets;
- All documents signed by the individual or the family/caregiver that acknowledge the responsibilities for receipt of the services;
- If tasks are performed requiring nurse delegation, the RN's documentation of training, supervising, and all other related information and documentation must be maintained by the service facilitation provider.
- All DMAS-99 forms. Documentation must include the observations of the individual made during the visits. The notes must also clearly document that he/she has discussed with the individual or family the appropriateness and adequacy of services.
- **The SF's assessment and reassessment documentation must note:**
 - Any change in the previously documented individual's medical condition, functional status, and social support, which may require modifications to the Plan of Care. The SF is expected to know the nursing facility criteria and to apply the criteria when assessing whether the individual continues to meet nursing facility

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criteria to receive CCC Plus waiver services. If the SF determines that the individual does not meet criteria for personal/respite care services, the SF must contact DMAS for a level of care review and to discuss discontinuation of services;

- A review of the Plan of Care with the individual/EOR and family/caregiver (as appropriate) to determine if it is adequate to meet the individual's needs or if changes need to be made;
- Dates of any lapse of services and why (e.g., hospitalization, nursing facility or inpatient rehab hospital admission and discharge dates, aide not available, etc.);
- The presence or absence of the attendant in the home during the visit. The individual/EOR and family/caregiver satisfaction with the services should be documented; and
- Any other services received by the individual.

All criteria and documentation requirements must be met for the entire time the service is provided in order to be reimbursed under the CCC Plus Waiver. The SF will not be reimbursed for services unless the individual is authorized for waiver services by the srv auth contractor.

TRANSPORTATION

Transportation is available to CCC Plus waiver members; however, is not a service available under the CCC Plus waiver. Transportation to providers of Medicaid services may be arranged through the DMAS transportation broker or through the appropriate CCC Medicare and Medicaid Plan. There are times that the aide/attendant or nurse may accompany the waiver individual to medical appointments or to other activities in the community. In no case will DMAS pay, through the CCC Plus Waiver, for mileage or other costs associated with transportation. The individual and/or aide/attendant assume all risks and responsibilities associated with transportation.

Transportation: Agency-Directed (AD) Services

Aides or nurses (for skilled respite services) may accompany the waiver individual to medical appointments, dialysis or community activities based on the following criteria:

- The agency will not be reimbursed for time beyond the already approved Plan of Care hours, or for vacations or overnight trips;
- The aide/nurse is essential for the safe transport of the individual (to assist in transfers, ambulation, behavior management, etc.);

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- No other individual is available and physically able to accompany the individual;
- The total time required by the aide/nurse for the day, including the time required to accompany the individual, does not cause the individual's weekly authorized hours to be exceeded. If, due to events beyond the provider's control, the number of hours is exceeded, the provider shall contact the srv auth contractor the next business day with the actual hours used for authorization of hours exceeded in the previous day's visit. The record must document why the hours were exceeded or the additional time may be deducted from another day as long as this does not jeopardize the individual's health and safety. The RN/LPN Supervisor must be notified in advance of the appointment, and must document (with the date) this approval in the RN notes in the individual's record;
- When the aide/nurse is required to accompany the individual based on the above criteria, DMAS will pay the agency for the time the aide/nurse is accompanying the individual to such appointments. This must be documented on the aide's/nurse's record; and
- DMAS will not pay the provider when the individual is accompanied by the aide to the hospital or essential medical appointments when the individual is being transported by ambulance.

Transportation: Consumer-Directed (CD) Services

As the attendant is the employee of the individual receiving CD services, any arrangements for transportation not paid for by the Medicaid program are between the attendant and the individual. This includes transportation necessary to implement the CD services Plan of Care (for example, to permit community access and activities). It is permissible for the attendant to transport the individual in the attendant's, the individual's, or the caregiver's vehicle with prior consent from the vehicle owner.

It is the responsibility of the individual or family member/caregiver to determine that the attendant has a valid Virginia driver's license, is registered in the Commonwealth of Virginia, and has vehicle insurance. Proof of the insurance coverage shall be received and shall cover the following.

The vehicle insurance shall cover the insured and/or the other person:

- Against loss from any liability imposed by law for damages;

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- Against damages for care and loss of services, because of bodily injury to or death of any person;
- Against injury to or destruction of property caused by accident and arising out of the ownership, use, or operation of such motor vehicle or motor vehicles within the Commonwealth of Virginia, any other state in the United States, or Canada;
- Subject to a limit exclusive of interest and costs, with respect to each motor vehicle of \$25,000 because of bodily injury to or death of one person in any one accident and, subject to the limit for one person, to a limit of \$50,000 because of bodily injury to or death of two or more persons in any one accident; and
- Subject to a limit of \$20,000 because of injury to or destruction of property of others in any one accident.

The total time required by the attendant for the day, including the time required to drive the individual, cannot exceed the individual's authorized weekly hours. If the total time required exceeds daily hours, additional time may be deducted from another day as long as this does not jeopardize the individual's health and safety, or the SF may submit a request within one business day to the srv auth contractor for a temporary increase in hours to provide reimbursement for the extra time in that day.

DMAS will not pay the attendant when the individual is accompanied by the attendant to the hospital or essential medical appointments when the individual is being transported by ambulance.

ADULT DAY HEALTH CARE (ADHC) SERVICES – AGENCY-DIRECTED (AD) ONLY

Service Definition

Adult day health care (ADHC) means long term maintenance or supportive services offered by a DMAS-enrolled community-based adult day care program, licensed by the Virginia Department of Social Services (DSS) as an Adult Day Care Center (ADCC). ADHC provides a variety of health, therapeutic, and social services designed to meet the specialized needs of waiver individuals.

ADHC may be offered either as the sole home-and community-based care service or in conjunction with other CCC Plus waiver services. A multi-disciplinary approach to developing, implementing, and evaluating each individual's POC is essential to ensuring quality ADHC services.

Services Units and Limitations

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The services offered by the ADHC Center must be designed to meet the needs of the individual. The range of services provided by the ADHC Center to each individual may vary to some degree and there must be a minimum range of services available to every individual attending ADHC through the CCC Plus waiver to include nursing, rehabilitation services coordination, nutrition, transportation coordination, social services, recreation, and socialization services.

DMAS will reimburse a per-diem fee to a DMAS-enrolled ADHC provider who has received authorization from the srv auth contractor for the claim dates of service. This is considered payment in full for all services rendered to that individual as a part of the individual's approved ADHC Plan of Care. A day is defined as attendance at the ADHC Center for six hours or more.

ADHC services shall not be provided, for the purpose of Medicaid reimbursement, to individuals who reside in NFs, ICFs/IID, hospitals, assisted living facilities that are licensed by VDSS that serve five (5) or more individuals, or group homes which are licensed by DBHDS.

ADHC services may take the place of personal care services either completely or for several days a week if it is determined that this would meet the needs of the individual. ADHC augments the social support system available to the individual by providing some assistance with activities of daily living. An individual may attend ADHC during the day and also receive personal care services in the morning or evening, or both, as appropriate to meet the identified needs.

Staff Responsibilities

Aide Responsibilities: The aide must provide assistance with ADLs (e.g., ambulating, transferring, toileting, eating or feeding, bathing, dressing), supervision of the individual, and assistance with the management of the individual's Plan of Care.

Nursing Responsibilities: These services include periodic evaluation, at least every 90 calendar days, of the nursing needs of each individual; provision of the indicated nursing care and treatment; responsibility for monitoring, recording, and administering prescribed medications; supervising the individual in self-administered medication; or general supervision of provider staff, who are certified through the Board of Nursing, in medication management and administering medications. Nursing functions also include the support of families in their home care efforts through education and counseling, and helping families identify and appropriately utilize health care resources.

Rehabilitation Services Coordination Responsibilities: These services are designed to ensure the individual receives all rehabilitative services deemed necessary to improve or maintain independent functioning, to include the coordination and implementation of physical therapy, occupational therapy, and speech therapy. The ADHC Center may arrange for individual rehabilitation treatment with an outpatient facility or independent rehabilitation provider. The coordination and implementation responsibilities of the ADHC Center include:

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- A referral for an evaluation by the appropriate rehabilitative discipline when necessary;
- If the ADHC chooses to offer rehabilitation on-site, then the provision of rehabilitation therapy in the ADHC Center by an independent rehabilitation provider may be offered, if the individual chooses to receive this service during ADHC service hours. Reimbursement for rehabilitation services are not part of the reimbursement fee for ADHC; and
- Coordination of any rehabilitative treatment plan into the individual's overall Plan of Care to include arrangement for transportation from the ADHC to the rehabilitation provider if necessary, and implementation by ADHC staff (designated by the Coordinator) of activities typically considered part of a home program prescribed by the therapist in conjunction with ongoing therapy.

Transportation Responsibilities: Every DMAS-approved ADHC Center must provide transportation when needed in emergency situations for any Medicaid individual to his or her home (e.g., the primary caregiver has an accident and cannot transport the individual home). Any ADHC Center which is able to provide individuals with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip fee (to and from the individual's residence). Refer to Chapter V for more billing information.

Nutrition Responsibilities: The ADHC Center must provide at least one meal per day, which supplies one-third of the daily nutritional requirements established by the U.S. Department of Agriculture. Special diets and counseling must be provided as necessary.

ADHC Coordination: The ADHC Coordinator, designated by the ADHC Director, must coordinate the implementation of the Plan of Care, make updates to the Plan of Care, record 30-day progress notes, and review the individual's daily log each week (when the log is completed by a program aide). The designation of a professional staff member as the ADHC Coordinator is intended to promote the maintenance of the individual's physical and mental health by coordinating services and providing assistance with any personal or social problems. This may be accomplished by individual or group discussion of problems, coordination with family, home, and other community agencies, counseling and referral to available community resources. In cases where the individual only receives ADHC and PERS, the ADHC Coordinator is responsible for ensuring the continued appropriateness of PERS.

Recreation and Social Activities Responsibilities: The ADHC Center must provide planned recreational and social activities suited to the needs of the individuals and designed to ensure community integration, encourage physical exercise, prevent deterioration, and stimulate social interaction.

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A multi-disciplinary approach to developing, implementing, and evaluating each individual's Plan of Care is essential to quality ADHC services.

Skilled Services and ADHC

An ADHC Center may choose to admit individuals who have skilled needs. Centers that do not employ professional nursing staff on site shall not be permitted to admit waiver individuals who require skilled nursing care to their centers. Examples of skilled nursing care may include: (i) tube feedings; (ii) Foley catheter irrigations; (iii) sterile dressing changing, or; (iv) any other procedures which require sterile technique. The ADHC shall not permit aide employees to perform such procedures unless it is performed in accordance with the Virginia Administrative Code 18VAC90-19-240 through 18VAC90-19-280, *Delegation of Nursing Tasks and Procedures*.

Re-Evaluation of the Adult Day Health Care (ADHC) Individual

The ADHC Center professional staff will continually assess the adequacy of ADHC services for each individual and shall meet and document changes in the individual's condition and Plan of Care at least every three months (this does not mean every 90 days). ADHC services may be authorized for up to seven (7) days of service based on the individual's needs and the center's availability. Any time the number of days an individual attends ADHC changes, the Plan of Care must be modified. The ADHC Coordinator must contact the srv auth contractor to request authorization for the change. The most recent Plan of Care must always be in the individual's record.

Whenever the professional staff determines that ADHC services, either alone or in combination with other community resources, are no longer appropriate for an individual, the ADHC Center will contact the srv auth contractor for authorization to conduct a re-evaluation of the individual's needs to ensure that the individual is receiving services which meet his/her needs and ensure the individual's continued health and safety in the community in a cost-effective health care setting.

DMAS will conduct annual level of care reviews of each individual according to established procedures described in Chapter VI of this manual.

ADHC Provider Individual Experience Survey

The individual experience survey is intended to determine an individual's experience in the setting where ADHC services are provided and to ensure their experience is consistent that of a home and community based setting. This requirement is for those members receiving ADHC services only. The contractor shall require that all providers of CCC Plus Waiver ADHC services maintain compliance with the provisions of the CMS HCBS rule as detailed in the provider agreement.

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As part of the annual assessment and plan of care review, the managed care organization's care coordinator or another entity as approved by the department shall conduct, an Individual Experience Survey in order to ensure that the member's services and supports are provided in a manner that comports with the setting provisions of the HCBS regulations in 42 CFR § 441.301(c)(4)-(5).

Each member receiving Medicaid ADHC services must receive an annual individual survey to determine their experience with their services and awareness of HCBS rights and requirements.

Conducting the Survey

The Individual Experience Survey must be conducted in person. The survey must include the member and also may include a family member or representative, as appropriate. ADHC services staff may participate as requested by the member and his/her family member/representative.

Inability to Provide ADHC Services

The provider is responsible for providing reliable, continuous care to any individual receiving Medicaid ADHC services for the number of hours per day or days per week as outlined on the Plan of Care. Any time the provider is unable to furnish ADHC services as determined in the Plan of Care, the individual or family/caregivers, as appropriate, must be notified immediately, to initiate other care arrangements for these individuals. Documentation of the contact must be recorded in the individual record. An ADHC provider may either sub-contract with another ADHC provider or may transfer the individual to another ADHC if they cannot provide the number of days per week as written in the Plan of Care.

The provider should explore with the individual, prior to the start of services, the individual's back-up plan or ability to go without service (in the event the provider cannot provide ADHC services). Back-up support can be provided by an informal network of family, friends or neighbors who can be called on as needed as long as this ensures the individual's needs are met.

The center may discharge waiver individuals from the center's services but not from the waiver. Written notice of discharge shall be provided, with the specific reason or reasons for discharge from the ADHC, at least 10 calendar days prior to the effective date of the discharge. In cases when the individual's or any other person's safety may be in jeopardy, the 10-calendar day notice shall not apply.

ADHC Provider Documentation Requirements

The ADHC Center shall maintain all records of each ADHC individual. These records shall be reviewed periodically by the DMAS staff or its designated agent who is authorized by DMAS to review these records.

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At a minimum, the ADHC records shall contain, but shall not necessarily be limited to:

- If the individual is newly enrolled in the waiver the LTSS Screening packet which includes: the Uniform Assessment Instrument (UAI), the Screening Authorization (DMAS-96), and the Screening Team Plan of Care (DMAS-97);
- The Interdisciplinary Plan of Care (DMAS-301) developed in collaboration with the waiver individual or family/caregiver, or both as may be appropriate, by the center's director, RN, and therapist, as may be appropriate, and any other relevant ADHC staff or individual's support persons;
- Documentation of interdisciplinary staff meetings that shall be held at least every three (3) months to reassess each waiver individual and evaluate the adequacy of the POC and make any necessary revisions. The initial ADHC POC can be used for documentation of interdisciplinary staff meetings and to make up to three (3) updates to the Plan of Care as long as the individual's status has not significantly changed. A new Plan of Care should be developed whenever re-evaluation indicates a need for significant changes to the Plan of Care;
- At a minimum, 30-day goal oriented progress notes recorded by the designated ADHC care coordinator. If a waiver individual's condition and treatment POC changes more often, progress notes shall be written more frequently than every 30 days;

Progress notes must:

1. Describe the individual's medical and functional status;
2. Note contacts made to or from the primary caregiver;
3. Indicate any change in social supports;
4. Indicate any other services received by the individual; and
5. Reference a review of the 30-day rehabilitative progress report and updated Plan of Care, if appropriate.

Note: DMAS does not require a form for recording the progress notes. However, the DMAS-99 form may be used for this purpose. At a minimum, the functional status section of the DMAS-99 form must be completed every 30 days by the RN or ADHC Coordinator;

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- The ADHC Center must obtain, or should document efforts to obtain, a rehabilitative progress report and updated treatment plan from any professional discipline involved in the individual's care every 30 days (e.g., physical therapy, speech therapy, occupational therapy, etc.);
- Daily logs of service provided (DMAS-302) - The daily log must contain the specific services delivered by ADHC Center staff. The log must also contain the actual arrival and departure time of the individual and a weekly signature by either the director, activities director, RN, social worker, or therapist employed by the center. The daily log must be completed on a daily basis, not before or after the date of service delivery. At least once a week, a staff member must chart significant comments regarding care given to the individual. If the staff member writing comments is different from the staff signing the weekly record, that staff member shall sign the weekly comments. A copy of this record shall be given weekly to the individual or family/caregiver and maintained in the individual-specific medical record;
- All contacts shall be documented in the individual's medical record, including correspondence, made to and from the individual, with family/caregivers, physicians, DMAS, the srv auth contractor, formal and informal service providers, and all other professionals related to the waiver individual's Medicaid services or medical care; and
- All Plans of Care.

The provider must use the approved DMAS forms or exact duplicates, where indicated.

Initiation of ADHC Services

Upon receipt of the referral and no later than the individual's fifth (5th) visit to the ADHC Center, the Plan of Care must be developed based on the needs identified by the ADHC professional staff's evaluation of the individual's need for nursing, transportation coordination, nutrition, social services, rehabilitation services coordination, PERS, recreation services, and socialization.

The staff will meet to develop a Plan of Care for that individual, using the ADHC Interdisciplinary Plan of Care (DMAS-301) to document the goals and objectives for each of the major areas of individual needs. The DMAS-301 must include the individual's name and Medicaid number, the ADHC provider identification number, signatures of the interdisciplinary team members present, the date services actually began, and the content of the Plan of Care. The DMAS-301 must also address all medications the individual takes, not just those received at the center.

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If, the ADHC Center evaluates the individual's needs and determines a change is needed to the number of days or hours the individual attends the ADHC, the ADHC Center must contact the srv auth contractor to request a change in authorization and at any other time the number of days an individual attends ADHC changes.

If ADHC is the individual's sole CCC Plus Waiver service, the provider must notify the eligibility worker at LDSS and DMAS Level of Care (LOCERI) staff of this decision immediately and provide DMAS with the documentation supporting its decision. If DMAS agrees that the provider should not start services, DMAS will send a letter of notification to the individual informing him/her of this decision and provide appeal rights.

The individual will have 30 calendar days to appeal the DMAS decision. Copies of the DMAS letter to the individual will be sent to the provider.

If DMAS disagrees with the provider's decision not to initiate care, DMAS will contact the provider in writing and inform them that services can be initiated.

If the ADHC determines that they should not initiate services and the individual is receiving at least one other CCC Plus Waiver (not PERS), the ADHC must send a letter of notification to the individual informing them of the decision not to provide services and provide appeal rights.

Monitoring the Individual's Condition and Changes to the Plan of Care for ADHC Services

The ADHC provider must assess the individual's functional, cognitive, and health status and record as necessary any changes to his/her condition in the 30-day progress notes and quarterly on the DMAS-301. The provider must know the DMAS criteria for ADHC services and take action to modify the Plan of Care as needed to ensure that the days and type of care and services are appropriate to meet the current needs of the individual.

If the ADHC determines the individual is no longer appropriate for attendance at the center, the provider may discharge the individual from their center, but not from the waiver. It is the responsibility of the provider to notify DMAS for a level of care review and to discuss discontinuation of services when the provider believes the individual no longer meets criteria for the waiver. Only DMAS may terminate the individual from the waiver. The provider should complete a Level-of-Care Review Instrument (DMAS-99LOC) and send it electronically through the DMAS ePAS system. If the provider has discharged the individual from its services, the provider must also send the Medicaid LTC Communication Form (DMAS-225) with the last date of service to DMAS. The DMAS-225 must also be sent to the LDSS to notify them of the individual's discharge from the provider's services. The discharge request must be made to the srv auth contractor.

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Change in Service Procedures for ADHC

Increase in Days of Service

The srv auth contractor must authorize any increase in days of service, either at the time of enrollment or afterward. The ADHC Center must contact the srv auth contractor as described in Appendix D of this manual and provide the following information:

- The reason the increase in days of service is needed; and
- The effective date of the increase.

(Note: If the individual receives personal care under the CCC Plus Waiver, the ADHC Center must have the provider information for the personal care provider/SF and must know how personal care services will be affected by the increase in the days of service.)

If the increase is denied, the srv auth contractor will indicate that the increase was denied and the reason for the denial. The srv auth contractor will send this copy to the ADHC Center. The srv auth contractor will transmit the authorizations or denials in the MMIS system. Once the entry has been made, the provider and individual will receive a computer-generated letter notifying them of the decision and providing appeal rights if a denial is issued. Individuals have the right to appeal any adverse action taken by the srv auth contractor. A copy of this letter must be maintained in the individual's record. If a denial is issued, the provider will also be notified by the srv auth contractor. The srv auth contractor will not retroactively approve increases.

Decrease in Days of Service (ADHC-Initiated Decrease)

- The ADHC Center will send the individual a letter giving the reason for the decrease, the effective date of the decrease, the individual's Medicaid number, and the individual's right to appeal.
- The decrease request must be submitted to the srv auth contractor, as described in Appendix D, who will process the change requests.
- Once the change request is processed, the provider and individual will receive a computer-generated letter verifying that the change was made.

It is not necessary for the ADHC to send the srv auth contractor the revised Plan of Care or supporting documentation unless this information is requested. The Plans of Care and the Community-Based Care Authorization Forms must be maintained in the individual's record. The Plans of Care and documentation-of-service delivery must be consistent with the information communicated to the srv auth contractor.

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PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

Service Definition

Personal Emergency Response System (PERS) is an electronic device that shall be capable of being activated by a remote wireless device and enables individuals to secure help in an emergency. PERS electronically monitors individual's safety in the home and provides access to emergency crisis intervention for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation via the individual's home telephone line or other two way voice communication system. When appropriate, PERS may also include medication monitoring devices.

DMAS will only reimburse services as defined in the service description, documented in the individual's approved Plan of Care, and that are within the scope of practice of the providers performing the service.

Criteria

PERS services are limited to those individuals, ages 14 and older, who live alone, are alone for significant parts of the day, have no regular caregiver for extended periods of time, or when there is no one else in the home who is competent or continuously available to call for help in an emergency. Individuals must be receiving PERS services and another CCC Plus Waiver service simultaneously. While medication monitoring services are also available to those receiving PERS services, medication monitoring units must be physician ordered and are not considered a stand-alone service.

An individual may not receive PERS if he/she has a severe cognitive impairment. The individual must be alert and cognitively able to operate the device appropriately.

Service Units and Limitations

There is a one-time reimbursement for installation of the unit(s) per provider, which shall include installation, account activation, individual and family/caregiver instruction, and removal of equipment when it is no longer needed. The PERS provider must properly install all PERS equipment into a PERS individual's functioning telephone line or other two way voice communication system within seven (7) days of the request unless there is appropriate documentation of why this time frame could not be met. The provider must furnish all supplies necessary to ensure that the system is working properly. A unit of service for PERS monitoring is a one-month rental price and for nursing services for the purpose of refilling the medication monitoring device is one-half hour.

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In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a registered nurse, a licensed practical nurse, or a licensed pharmacist. The units can be refilled every 14 days.

Additional PERS Requirements

The PERS installation shall include local seize line circuitry, which guarantees the unit to have priority over the telephone connected to the console unit should the phone be off the hook or in use when the unit is activated.

A PERS provider must maintain all installed PERS equipment in proper working order and have back-up monitoring capacity in case the primary system cannot handle incoming emergency signals.

Standards for PERS Equipment

All PERS equipment must be approved by the Federal Communications Commission and meet the Underwriters' Laboratories, Inc. (UL) safety standard. The PERS console unit must provide hands-free voice-to-voice communication with the response center. The console shall be waterproof; shall automatically transmit to the response center a low-battery alert signal prior to the battery losing power; be able to be worn by the individual; and have the capacity to be automatically reset by the response center after each activation in order to allow subsequent signals to be transmitted without requiring a manual reset by the individual or family/caregiver.

A PERS provider shall furnish education, data, and ongoing assistance to DMAS and/or the srv auth contractor to familiarize staff with the service, allow for ongoing evaluation and refinement of the program, and shall instruct the individual, family/caregiver, and responders in the use of the PERS service.

The PERS provider has the primary responsibility to furnish, install, maintain, test, and service the PERS equipment, as required, to keep it fully operational. The provider shall replace or repair the PERS device within 24 hours of the individual's notification of a malfunction of the console unit, activating devices, or medication monitoring unit while the original equipment is being repaired.

The emergency response activator must be activated, either by breath, touch, or by some other means, and must be usable by persons who have visual or hearing impairments or a physical disability. The emergency response console must be capable of operating without external power during a power failure at the individual's home for a minimum period of 24 hours and automatically transmit a low-battery alert signal to the response center if the back-up battery is low. The emergency response console unit must also be able to self-disconnect and redial the back-up monitoring site without the individual resetting the system in the event it cannot get its signal accepted at the response center.

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Monitoring agencies must be capable of continuously monitoring and responding to emergencies under all conditions, including power failures and mechanical malfunctions. It shall be the PERS provider's responsibility to assure that the monitoring agency and the provider's equipment meets all requirements. The monitoring agency must be capable of simultaneously responding to multiple signals for help from individuals' PERS equipment.

The monitoring agency's equipment must include the following:

- A primary receiver and a back-up receiver, which must be independent and interchangeable;
- A back-up information retrieval system;
- A clock printer, which must print out the time and date of the emergency signal, the individual's identification code, and the emergency code that indicates whether the signal is active, passive, or a responder test;
- A back-up power supply;
- A separate telephone service;
- A toll-free number to be used by the PERS equipment in order to contact the primary or back-up response center; and
- A telephone line monitor, which must give visual and audible signals when the incoming telephone line is disconnected for more than 10 seconds.

The PERS provider must maintain detailed technical and operations manuals that describe PERS elements, including the installation, functioning, and testing of PERS equipment; emergency response protocols; and record keeping and reporting procedures.

Provider Documentation Requirements

1. The PERS Request Form (DMAS-100A) or the current DMAS approved electronic request, to be completed by the provider/SF may serve as the PERS Plan of Care provided it adequately documents the need for the service, the type of device to be installed, and description of ongoing services, including training regarding the use of the PERS. Information from this form must be submitted to the srv auth contractor for authorization to occur and also maintained in the individual's record;

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2. A PERS provider must maintain a data record for each individual utilizing PERS at no additional cost to DMAS or the individual. The record shall document all of the following:
 - Delivery date and installation date of the PERS;
 - Individual/caregiver signature verifying receipt of PERS device;
 - At a minimum monthly testing to verify that the PERS device is operational;
 - Updated and current individual responder and contact information, as provided by the individual, or the individual's care provider; and
 - A case log documenting individual system utilization and individual, family/caregiver, provider, SF, or responder contacts/communications;
3. The PERS provider shall document and furnish, within 30 days of the action taken, a written report to the primary provider for each emergency signal, which results in action taken on behalf of the individual. This shall exclude test signals or activations made in error.

This written report must be furnished to the agency provider/SF, or in cases where the individual only receives ADHC services, to the ADHC provider. This information must be maintained in the individual's record at the PERS provider agency. The PERS provider must retain a copy of the DMAS-100A in the individual records.

4. The PERS provider must obtain and keep on file a copy of the most recently completed DMAS-225 for the individual. The provider must document efforts to obtain a copy of the DMAS-225 until it is received from the personal care, respite care, SF or ADHC provider.

PRIVATE DUTY NURSING (PDN)

Service Definition

PDN means in-home nursing services provided for individuals enrolled in the CCC Plus waiver with a serious medical condition and/or complex health care need. The individual requires specific skilled and continuous nursing care on a regularly scheduled or intermittent basis performed by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of a registered nurse. PDN services may include consultation and training for the primary caregiver, or other providers of care.

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PDN is offered to individuals (21 years of age or older) who would otherwise require a specialized care nursing facility placement and supplemented care rendered by a primary caregiver; PDN may be used:

1. To provide supports in the individual's home setting;
2. To accompany the individual to medical appointments; or
3. To facilitate community integration (church, theater, etc.).

Other waiver services can be used in conjunction with PDN such as personal care and skilled respite care, but may not be performed at the same time or duplicate any other service received.

PDN services are authorized by DMAS or its contractors and rendered according to a plan of care (CMS-485) certified by a physician as medically necessary to enable the individual to remain at home rather than in a hospital or nursing facility. PDN may be provided to individuals living in the community who have been authorized to receive certain HCBS as an alternative to receiving services in an institutional setting. PDN includes specific treatments, procedures and individual/primary caregiver training/education related to the developed and certified plan of care goals. PDN services will also meet the medical needs and ensure the health, safety and welfare of the individual while residing in the community.

PRIVATE DUTY NURSING (PDN) CRITERIA

Private Duty Nursing (PDN) may be authorized through the CCC Plus waiver for individuals who are chronically ill or have a significant disability, needing a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability.

To qualify for PDN, the *PDN Adult Referral Form (DMAS-108)* or the *PDN Pediatric Referral Form (DMAS-109)* must be completed and the individual must be determined to meet Category A- be dependent on a ventilator, or Category B-must meet all eight (8) specialized care criteria for complex tracheostomy care:

Category A:

Individual dependent on mechanical ventilator; or

Category B:

Individuals who have a complex tracheostomy as defined by:

- Tracheostomy with the potential for weaning off of it, or documentation of attempts to wean with subsequent inability to wean;

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- Nebulizer treatments ordered at least four times a day or nebulizer treatments followed by chest physiotherapy provided by a nurse or respiratory therapist at least four times a day;
- Pulse oximetry monitoring at least every shift due to unstable oxygen saturation levels;
- Respiratory assessment and documentation every shift by a licensed respiratory therapist or nurse;
- Have a physician's order for oxygen therapy with documented usage;
- Receives tracheostomy care at least daily;
- Has a physician's order for tracheostomy suctioning; and
- Deemed at risk to require subsequent mechanical ventilation.

PDN is generally provided in the waiver individual's primary residence, as determined on initial enrollment into the waiver.

For individuals receiving PDN services through FFS Medicaid, DMAS will monitor the individual's status and provision of nursing services by telephone contact with the provider as needed and review required documentation routinely submitted by the provider. DMAS will perform annual Level of Care (LOC) assessments in the individual's home. For individuals enrolled with a MCO, these functions will be performed by a care coordinator.

PDN hours are based on the assessed skilled needs of the individual. These hours may be authorized up to a maximum of 112 hours per week, per the DMAS-108.

Primary Caregiver Responsibilities

It is the responsibility of the primary caregiver to assure and provide all care when the private duty nurse is not available. Documentation in the medical record must state the name and phone number of the trained primary caregiver. This trained primary caregiver shall also have a back-up system (i.e.: caregiver) available in emergency situations. Due to the complex medical care needed for individuals receiving PDN services, they may not be left alone at any time.

When an individual approved for PDN services also receives personal care, the primary caregiver is responsible for providing all of the skilled nursing needs. The aide/attendant may only provide the individual with personal care services and cannot be left alone with the individual at any time.

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The trained primary caregiver and a back-up caregiver name and phone number should be documented in the medical record of the individual. The back-up caregiver shall accept responsibility for the oversight and direct care of the individual in case of an emergency, and ensure the health, safety and welfare of the individual when the primary caregiver is ill, incapacitated, or unavailable for any reason. The back-up caregiver will do so without Medicaid compensation and shall be trained in the skilled technologies required by the individual.

When care for enrolled individuals is interrupted due to their primary caregiver's emergency unavailability and an adequate back-up system is not available, hospitalization or placement in a specialized nursing facility shall occur as a temporary last resort alternative.

PRIVATE DUTY NURSING AGENCY RESPONSE TO REFERRAL

Individuals choosing to receive PDN services must do so by choosing a PDN provider enrolled with DMAS to provide the services. Once the agency has accepted the PDN referral, the RN supervisor must make the initial home assessment visit on or before the actual initial start of services date.

Providers shall not begin PDN services until the LTSS Screening packet is received from the screening team or DMAS, and DMAS has approved PDN services. It is the provider's responsibility to review and ensure the receipt of a complete and accurate LTSS Screening packet.

The first date of PDN services cannot be before the physician signature date on the DMAS-96 and must be on the same date as the DMAS PDN service effective date as identified on the Skilled Private Duty Nursing Authorization.

DMAS will coordinate with the chosen nursing provider to assist with a smooth transition to PDN services. The PDN provider shall make available any documentation requested by DMAS as part of the required assessments and home visits.

The RN or LPN providing PDN services will do so according to the nursing services ordered by the physician, in accordance with all Medicaid regulations, policies and provider policies.

DMAS PDN INITIAL REVIEW

DMAS will work with the screening entities, the physician, the individual/primary caregiver and providers to assure a safe and smooth transition to HCBS. In conjunction with the referral assessment for eligibility criteria, the DMAS review shall include:

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1. Verification that the primary caregiver's training needs have been met to ensure the safety of the individual while living in the community;
2. Verification that the discharge planner has included the delivery of medical equipment to the home;
3. Verification that the PDN provider initial assessment home visit has been performed and completed by the RN supervisor; and
4. Verification of the DMAS authorized first date of PDN services.

DMAS will perform an initial assessment within 14 business days of PDN service initiation. The purpose of this assessment is to assure services are rendered according to the physician orders and the assessed needs of the individual. This assessment will include all documentation submitted to DMAS and the required documentation available in the home. DMAS will assure the individual is living in a safe environment, verifies the primary caregiver/back-up caregiver and ensure choice of services and providers.

PRIVATE DUTY NURSING SERVICES VISIT REQUIREMENTS

At a minimum, supporting documentation in the form of physician's orders on the CMS-485, PCA plans of care (97A/B), daily PDN nurses notes and Supervisory Monthly Summary (DMAS-103) forms must clearly describe the following:

- The type of skilled procedures to be performed by the skilled private duty nurse and the type of personal care services being performed;
- The complexity of steps needed to complete each procedure;
- The extent to which the skilled private duty nurse is called upon to use nursing knowledge and expertise to make an assessment, follow-up with a physician, or adjust orders/plans of care; and
- Documentation of all care provided by the skilled private duty nurse.

INITIAL PDN ASSESSMENT VISIT

The initial PDN assessment visit is performed by the provider RN Supervisor before the start of PDN or any other waiver services. This visit serves as the admission visit of the individual and involves an assessment of all of the health care needs, social and psychological needs, and

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additional service needs found as a result of this visit. The provider RN supervisor should also ask and document any signals or alerts the individual uses in the event of an emergency or when the individual is under duress. This visit must occur in the individual's home and be documented on the Provider RN Home Assessment (DMAS-116). A copy of the assessment (DMAS-116) must be sent to DMAS within two (2) business days of the initial visit.

The Physician's Home Health Certification and Plan of Care – CMS- 485 (with or without MD signature) must also be sent to DMAS within two (2) business days of the initial visit. The CMS-485 must include the specific number of nursing hours needed per day (i.e. not a range of hours). The provider must submit a service authorization request for the number of hours the agency is able to adequately staff. Once the assessment and CMS-485 is received and reviewed by DMAS, the authorization will be completed. DMAS will work with the individual/primary caregiver to identify additional nursing agencies to cover the remaining PDN hours the agency is unable to staff; for individuals enrolled with a MCO, this function will be performed by a care coordinator. Medicaid reimbursement cannot be made until the provider receives service authorization from DMAS. Failure of the provider to ensure timely submission of the required assessments may result in retraction of all PDN payments for the period of time of the delinquency.

An initial assessment visit must also be made when an individual is re-enrolled after discharge from services or is a transfer from another provider or another payer source.

PDN services are documented on Skilled Nursing Notes for dates rendered in accordance with the physician orders.

Monthly Supervisory Visits

The RN Supervisory Visit must be performed every 30 days to provide oversight for PDN services offered to the individual in the home. These visits include:

1. An assessment of the individual based on their skilled needs;
2. Review of the home medical record;
3. A determination that health care needs are met in the home;
4. Documentation of the individual's satisfaction and choice of services;
5. Documentation of satisfaction of service plan meeting their personal goals;
6. A review of the CMS-485 to ensure physician orders are accurate, current and being followed; and
7. An assessment of personal care services when provided by the PDN provider agency.

The Monthly Supervisory Visit (DMAS-103) must be submitted to DMAS within 5 days following the end of the month in which the visit is due.

These visits are documented on the PDN Supervisory Monthly Summary Visit (DMAS-103). At least every other month, the supervisory visit shall be made in the primary residence of the

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individual. The individual receiving PDN services must be present during every supervisory monthly visit.

The home medical record shall be easy to find, organized and legible. The provider shall assure the information in the home record is current. The agency may purge the home record but must assure at least two weeks of data remain in the home record.

PHYSICIAN SUPERVISION/CERTIFICATION AND RECERTIFICATION FOR THE PLAN OF CARE

Individuals receiving PDN services must be under the care of a licensed physician authorized to practice in the Commonwealth of Virginia.

The following documentation is required:

- A written physician's certification statement, which may be documented on the CMS-485 Plan of Care, in the form of physician orders, must be in the individual's medical record in the PDN provider's office and at the individual's home. Provider agencies that elect not to use the CMS-485 may develop their own form that must contain all of the elements and requirements as set forth in regulation and in this manual for the CMS-485. The statement of certification of medical necessity must be found on the form and must include:
- Physician certification statement of the individual's need for PDN care;
- Identification of primary care physician who has agreed to manage the medical care of the individual;
- Order must include the identification of the type, scope, amount, duration and frequency of services;
- Name and current address, home and cell phone numbers of the individual;
- Individual's date of birth, Medicaid ID number, PDN start of care date as well as the 60 day certification period;
- Choice of services made by the individual;
- Personal goals of the individual;
- A plan and certification for furnishing services to the individual which is reviewed, updated and signed by the physician every 60 days;

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- The diagnosis of the individual which is directly associated with the services ordered and ICD code;
- A list of current medications, treatments, allergies and equipment ordered;
- Measurable goals for care/services;
- Both the dated RN and Physician signatures; and
- Current signed CMS-485 to be kept in the individual's home.

All new or modified orders must be signed and dated by the physician and kept with the current CMS-485. These orders must be included on the next CMS-485, if appropriate.

Verbal orders may be received by a registered nurse. When a verbal order is taken by a LPN, the agency provider RN Supervisor must assure the accuracy of the order and its inclusion in the next CMS-485. All verbal orders must be signed and dated by the physician, per medical standards of practice (typically within 3 days).

To assure all of the care needs of the individual are met, the most recent CMS-485 must be kept in the individual's home and easily accessible at all times. This CMS-485 will assist the nurse in cases of emergencies, substitution or when there is more than one nurse providing care.

Orders for Skilled Care (CMS-485, Block 21)

Discipline and Treatments orders must include the following information for these specific technologies:

BIPAP/ CPAP/ Ventilators

- Machine or Vent model
- Current MD ordered Vent settings
- Orders for Vent use, i.e.- time to be used, weaning schedule (if ordered)

Tracheostomy

- Trach manufacturer, size, and back up trach size
- With cuff use - Please specify when cuff is to be inflated (with vent use, with sleep only, while eating, etc.). Inflate with air or water and amount
- Trach Care to include:
Frequency of change and LOCATION if not done at home
Specific ostomy site care and frequency per day
Inner cannula care or change, if applicable
Trach suction catheter size and frequency

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Oxygen

- Should be ordered as a medication to include: dose/amount, time to be used (PRN/with sleep/continuous), route

Pulse Oximeter

- Include high/low limits and orders in response to exceeding those limits
- Frequency of use

Nutrition

- Specify PO, enteral feeding or TPN
- Include specific PO diet, i.e. consistency and indicate if thickener is required for liquids
- Enteral feeding should specify formula name, amount, frequency and delivery method
- Gastrostomy site care, frequency of care, tube size, and changing schedule must be ordered

Catheter Care

- Foley, size, change frequency, irrigation if ordered
- Straight catheter, size, scheduled or PRN, irrigation if ordered

Wound Care

- Site, type, specific treatment orders, measurements of wound if applicable
- Include name and phone number of any agency that provides RN skilled wound care visits

Infusion Therapy

- Type of infusion fluids
- IV site, care orders
- Dosage and daily time schedule for giving the infusion
- Include name and phone number of any agency that provides infusion therapy visits

RN SUPERVISOR RESPONSIBILITIES

Using a person-centered planning team approach to nursing services, the provider RN supervisor shall:

- Ensure choice of services is made by the individual, legally authorized guardian, or responsible party if a minor;
- Ensure personal goals of the individual are respected;
- Conduct the initial evaluation visit to initiate PDN services in the primary residence;
- Regularly evaluate the individual's status and nursing needs and notify DMAS if the individual no longer meets the LOC criteria for the waiver;

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- Complete the CMS-485 every 60 days and as necessary for revisions. The new CMS-485 should be sent to DMAS at the beginning of each new certification period;
- Perform monthly skilled nursing assessment, every 30 days, using the *Monthly Supervisory Visit (DMAS-103)* (the monthly nursing assessment cannot be made by the nurse providing care in the home);
- Coordinate services;
 - Inform the physician, DMAS and other personnel of changes in the individual's condition and needs;
 - Contact DMAS if an individual does not meet PDN criteria;
 - Educate the individual/primary caregiver in meeting nursing and related goals;
 - Supervise and educate other personnel involved in the individual's care;
- Ensure all nurses have a *PDN Skills Checklist (DMAS-259) form* completed by the RN supervisor prior to assignment to an individual; review with each nurse all skills listed on the DMAS-259 and have the nurse demonstrate or explain in detail how they would perform each task. Nurses may not complete the DMAS-259 form on themselves. PDN staff may not complete this form on their nursing peers;
- Ensure availability of a supervising RN for 24 hours per day to address concerns that may arise with PDN individuals;
- Notify DMAS of any major problem or changes in an individual's family/social situation or primary residence;
- Ensure nurse supervisors do not work as a private duty nurse on cases they supervise;
- Ensure that all nurses and caregivers are aware that timesheets must be accurate with arrival and departure time of the nurse and that falsifying timesheets is fraudulent; and
- Ensure that respite documentation is kept separate from regular nursing documentation and labeled as respite.

TWO AGENCIES PROVIDING PRIVATE DUTY NURSING

When two agency providers share an individual's care, the agencies must coordinate the services between each other. Weekly communication between agencies in shared cases is encouraged regarding PDN hours, billing, and health, safety or welfare issues.

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Both providers shall:

- Maintain an individual's medical record with all required documentation;
- Maintain CMS-485 and medication sheets;
- Send all verbal orders to the co-sharing agency;
- Track the annual respite hours being used;
- Perform monthly supervisory visits every 30 days; and.
- Maintain weekly communication between agencies in shared cases is encouraged regarding PDN hours, billing, and health, safety or welfare issues.

CONGREGATE PDN

Congregate PDN is skilled nursing simultaneously provided to three or fewer waiver individuals who reside in the same primary residence.

Congregate PDN may be authorized in conjunction with PDN in instances when individuals must be out of the home for part of the authorized PDN hours.

Only one nurse shall be authorized to care for no more than two waiver individuals receiving congregate nursing. When three individuals share a home, nursing ratios shall be determined by DMAS or its designated agent, based on the care needs of all of the individuals who are living together.

DMAS ONGOING REVIEW

For FFS individuals, DMAS will monitor the individual's status and the provision of nursing services by telephone contact with the provider, review provider Supervisor Monthly Visit Notes, review skilled nursing notes, as needed, and will perform the annual DMAS visits.

Annual eligibility assessment visits, performed by DMAS for all individuals receiving PDN services, shall include, but are not limited to:

- Reviewing the most recent CMS-485 for appropriateness of the level, amount, type, and quality of services provided;
- Monitoring the cost-effectiveness of the individual's care in the community;

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- Reviewing the last three months of Supervisory Monthly Summary notes (DMAS 103);
- Discussing customer satisfaction and choice;
- Assessing that health, safety and welfare needs are being identified and met by the provider; and,
- Reviewing skilled nurse's notes.

PRIVATE DUTY NURSING SERVICE UNITS AND LIMITATIONS

Adults are eligible for a maximum of 112 hours per week of PDN hours due to complex care needs and must be ventilator dependent or meet complex tracheostomy criteria on the Private Duty Nursing Adult Referral form (DMAS-108).

The following are service units and limitations:

- PDN is billed in hourly units.
- A day is defined as 24 hours which begins at 12:00 AM and ends at 11:59 PM.
- A week is defined as Sunday through Saturday for the purpose of authorization.
- Payment is available for allowable activities which are authorized and provided by qualified providers and in accordance with an approved CMS-485.
- Nurses shall not transport individuals receiving PDN. Medicaid will not reimburse for transportation to school, or other localities as these are the primary caregiver's responsibility.
- In no instances are PDN services to be provided for the convenience of other family members living in the individual's home.
- PDN services cannot be provided simultaneously with respite care or personal care.
- PDN services shall not be billed to include time the individual is receiving hospital emergency room care or during emergency transport of the individual to such facilities and/or hospitalization. The RN or LPN shall not transport the waiver individual to such facilities.

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DECREASE OR INCREASE IN PDN HOURS

DMAS or its designated agent shall have the final authority to approve or deny a requested change to an individual's PDN hours. Any request for an increase to an individual's PDN hours shall be authorized by DMAS or its contractors and accompanied by adequate documentation justifying the increase.

The provider may request a decrease in the amount of authorized PDN hours if the revised PDN hours are appropriate and based on the needs of the individual. The provider agency shall work with DMAS staff for coordination and final approval of any decrease in service delivery. A revised PDN authorization shall be completed by DMAS for final authorization and forwarded to the provider agency.

When the RN Supervisor determines that a decrease/increase in hours of service is warranted, he or she will contact the DMAS Health Care Coordinator (HCC) assigned to the individual immediately. DMAS will work with the RN Supervisor to re-evaluate the needs of the individual based on the assessed information from the provider.

A PDN authorization will be provided by DMAS to the nursing agency and will include the number of PDN hours to be provided per week and the effective date the change will occur.

The provider shall be responsible for documenting the physician's verbal orders and for inclusion of the changes on the recertification POC (CMS-485) in accordance with the DMAS PDN Authorization form. The provider agency's RN supervisor, who is responsible for supervising the individual's care, shall use a person-centered approach in discussing the change in PDN hours with the individual and individual's representative to include documentation in the individual's record. The DMAS or its service authorization (SA) contractor shall notify in writing the individual or individual representative of the change. Reimbursement will not occur without authorization from DMAS staff. The provider must ensure tasks performed meet the current needs of the individual.

If the decision is to deny, reduce, terminate, delay, or suspend a covered service, written notice will identify the individual's right to appeal the adverse decision, in accordance with *42 CFR §200 et seq.* and *12VAC30-120-1780 et seq.* The provider also has the right to appeal adverse decisions to DMAS.

Regardless of the type of change (increase/decrease of hours/services), DMAS will send a letter to the individual/primary caregiver with the change in hours, the effective date of the change, and include appeal rights. Appeal rights can be found at the end of this chapter. A copy of this letter must be filed in the individual's record at the agency.

PDN DOCUMENTATION REQUIREMENTS

Provider Required Documentation - Office Records

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The provider shall maintain all records of each individual receiving PDN services. These records shall be separated from those of non-HCBS, such as companion or home health services. These records shall be reviewed periodically by personnel who are authorized by DMAS.

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At a minimum, these records shall contain:

1. All assessments and plans of care, all PDN and all LTC Communication forms (DMAS-225), all medical orders-verbal orders as well as the CMS-485 authorizing PDN, and the age appropriate PDN Adult Referral form (DMAS-108);
2. The physician's certification for services (CMS-485) obtained prior to the service start date and updated every sixty (60) days;
3. The initial assessment (DMAS-116) completed in the home by a registered nurse;
4. The Monthly Supervisory Visit (DMAS-103) completed every 30 days;
 - RN supervisor's notes documented and dated during significant contacts with the case and during supervisory visits to the individual's home;
 - Include AM and PM behind time notation, such as "in" and "out" time of visits; include printed name and initials and title when documenting; assure time sheets and nursing notes are completed daily, at the end of each shift, and copies or originals are left in the individual's home record;
 - When the supervisory visit is missed, documentation must include the reason and the make-up assessment must occur within five (5) days. When there is an interruption in services such as hospitalization, the post hospital RN supervisory visit may serve as the supervisory visit and following visits will resume accordingly;
5. The PDN note must include, but is not limited to, all PDN care provided, as ordered, on the CMS-485, assistance with activities of daily living, administration of medications and any other medical needs and the monitoring of the individual's health status and physical condition. When there are health, safety and welfare concerns, documentation must indicate supervisory and DMAS notification and the appropriate Adult Protective Services/Child Protective Services referrals. The PDN notes must be signed and dated by the nurse providing the care;
6. All correspondence with the individual, DMAS, and the designated SA contractor;
7. Reassessments made during the provision of services;
8. Contacts made with family, physicians, formal and informal service providers, and all professionals involved in the individual's Medicaid services or medical care;

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9. The name and phone number of a back-up caregiver who will provide the alternate care usually provided by the trained primary caregiver, in the event of an emergency;

10. Comments or observations recorded about the individual. The nurse's comments shall include, but not be limited to, observation of the individual's physical and emotional condition, daily activities, and the individual's response to services rendered; and

11. To assure all services are rendered, the signatures of the individual or primary caregiver and the private duty nurse must be documented once each shift when PDN and Respite care is completed. Signatures, times, and dates shall not be placed on the notes prior to the delivery of service for that day. An employee of the provider shall not sign for the individual or caregiver. Documentation verified by signature of the individual or primary caregiver must include arrival and departure time of the nurse.

Provider Required Documentation – Home Records

Documentation in the home record shall be kept in the home at all times. Documentation should be kept in a binder which is kept organized and in a designated place in the home. Caregivers should know the location of the nursing binder.

This home record/binder shall include all of the following:

1. Current CMS-485
2. Medication Administration Records (MAR)
3. Two (2) weeks of nursing shift notes
4. Additional physicians orders received during the certification period
5. Treatment records
6. Nursing assessments and documentation
7. Emergency contact information
8. DNR orders (if applicable)

Nursing documentation must be completed during the shift in which the PDN care is provided. Information documented after the shift is provided must be identified as a "late entry".

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HIPAA law shall be observed regarding all documentation and medical records. All nursing documentation must be maintained in the home record.

ENVIRONMENTAL MODIFICATIONS

Service Definition

Environmental Modifications (EM) are physical adaptations to the individual's primary residence, and/or primary vehicle used by the individual, which provide direct medical or remedial benefit to the individual. These adaptations are necessary to ensure the health, welfare, and safety of the individual, or directly enable the individual to function with greater independence in the home. Without these adaptations, the individual would require institutionalization. The purpose of Environmental Modifications is to modify, not make general improvements to the home. Environmental Modifications are for pre-existing structures.

Criteria

The EM services are available to individuals in the CCC Plus waiver. Individuals who qualify for these services must have a demonstrated need for equipment or modifications of a remedial nature or medical benefit offered in an individual's primary residence, or primary vehicle used by the individual, community activity setting, or day program to specifically improve the individual's personal functioning and is medically necessary. These physical adaptations shall be necessary to ensure the health, welfare and safety of the individual. These services are not considered a "stand alone" service and can only be authorized in conjunction with at least one other authorized waiver service.

Medically necessary includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the State Plan for Medical Assistance that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit.

Allowable Activities

- Physical adaptations to the individual's primary residence necessary to ensure an individual's health, safety and welfare; or
- Physical adaptations to the individual's primary residence that enable an individual to live in a non-institutional setting and to function with greater independence that do not increase the square footage of the primary place of residence; or
- Modifications to the primary vehicle being used by the waiver individual. This service does not include the purchase or lease of vehicles or general repair of vehicles. Repairs of modifications that have been reimbursed by DMAS shall be covered.

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Examples of Environmental Modifications

Such modifications may include, but be limited to the following:

- Installation of non-portable wheelchair ramps and grab-bars at the primary residence;
- Widening of doorways and other adaptations to accommodate wheelchairs;
- Modification of bathroom facilities to accommodate wheelchairs (not strictly for cosmetic purposes);
- Installation of specialized electrical and plumbing systems required to accommodate the medical equipment and supplies which are necessary for the individual's welfare; and
- Modifications may include a generator for individuals who are dependent on mechanical ventilation for 24-hours a day and when the generator is used to support the medical equipment and supplies necessary for the individual's welfare.

Collaboration

The provider and the waiver individual may collaborate with multiple providers in order to complete a modification, for example:

1. A Physical Therapist, Speech Therapist or Occupational Therapist may be accessed to evaluate the needs for environmental modifications; and/or
2. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's needs and subsequently act as Project Manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the Rehabilitation Engineer may actually design and personally complete the modification.

For example, a Rehabilitation Engineer might be required if:

- The Environmental Modification involves combinations of systems which are not designed to go together; or
 - The structural modification requires a Project Manager to assure that design and functionality meet ADA accessibility guidelines.
3. A building contractor may design and complete the structural modification;
 4. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor or Rehabilitation Engineer; or

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5. A durable medical equipment (DME) provider enrolled with DMAS may be used to bill for modifications.

Collaborative funding is allowed for Medicaid covered services; however, due to the Federal rules, the provider would need to break down the parts. For example, if an individual needs a wheelchair van lift, the provider needs to determine the cost for the floor of the van, the cost for the ties, and the cost for the lift. For the parts funded with Medicaid dollars, the provider must accept payment as payment in full. The provider will need to delineate which parts are Medicaid funded and which are private pay or another funding source, e.g., DARS, Assistive Loan Fund Authority, church or other private funding, etc.

Service Units and Service Limitations

- a. EM shall be available for a maximum Medicaid-funded amount of \$5,000 per household per SFY (State Fiscal Year – July 1 to June 30).
- b. Costs for EM cannot be carried over from one plan of care year to the next. Each item shall be service authorized by the DMAS Srv Auth contractor for each SFY year. Unexpended portions of this maximum amount shall not be accumulated across one or more years to be expended in a later year.
- c. When two or more individuals receiving waiver services live in the same home, the EM shall be shared to the extent consistent with the type of requested modification.
- d. Only the actual cost of material and labor is reimbursed. There shall be no additional markup. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered non-covered.
- e. EM shall be carried out in the most cost effective manner possible to achieve the goal required for the individual's health, safety, and welfare.
- f. All services shall be provided in the individual's primary residence in accordance with applicable state or local building codes and appropriate permits or building inspections, which shall be provided to the DMAS designated Srv Auth contractor.
- g. Proposed modifications that are to be made to rental properties must have prior written approval of the property's owner. Modifications to rental properties shall only be valid if it is an independently operated rental facility with no direct or indirect ties to any other Medicaid service provider.
- h. Modifications may be made to a vehicle if it is the primary vehicle used by the waiver individual. This service shall not include the purchase of, or the general repair of, vehicles (repairs of modifications which have been reimbursed by DMAS shall be covered).

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- i. Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be authorized through the DMAS Srv Auth Contractor if more than five (5) visits have been provided to the individual. Visits are individual-specific, not provider-specific.
- j. The EM provider shall ensure that all work and products are delivered, installed and in good working order prior to seeking reimbursement from DMAS. The date of service on this provider's claim shall be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the approval dates.
- k. The service authorization shall not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) shall be submitted to the DMAS designated Srv Auth contractor for revision to the previously issued service authorization and shall include justification and supporting documentation of medical needs.
- l. A copy of the provider's cost estimate for labor and materials for an environmental modification must be submitted to the service authorization contractor.

Service Exclusions

- Environmental Modifications cannot take place at any site owned and operated by a residential program.
- Environmental Modifications are to modify, not furnish, new additions to a home.
- Environmental Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. The EM service does not include those adaptations or improvements to the home, which are of general utility and are not of direct medical or remedial benefit to the individual. Such non-covered items include, but shall not be limited to: carpeting, roof repair, central air conditioning, general maintenance and repairs to a home, additions or maintenance of decks, maintenance/replacement addition of sidewalks, driveways, carports, or adaptations which only increase the total square footage of the home, etc.
- Environmental Modifications shall not be covered by Medicaid for general leisure, or diversion items, or those items that are recreational in nature or those items that may be used as an outlet for behavioral supports. Such non-covered items include, but shall not be limited to, swing sets, playhouses, climbing walls, trampolines, hot tubs, elevators, fences, pools, basketball or other courts, protective matting or ground cover, sporting equipment or exercise equipment, such as special bicycles or tricycles, etc.

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- DMAS does not repurchase items paid for with waiver funds unless those items have specific timeframes of usefulness (i.e., quarterly maintenance on lifts). Additional repairs are considered on an individual basis.
- Providers that supply environmental modifications for an individual may not perform assessment/consultation, design or inspect environmental modification for that individual.
- There shall be no duplication of EM services within the same plan of care year or EM services within the same primary residence, such as multiple wheelchair ramps or previous modifications to the same room.
- EM shall not include the costs of removal or disposal, or any other costs, of previously installed modifications, whether paid for by DMAS or any other source.
- Excluded shall be modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, the Virginians with Disabilities Act (§ 51.5-1 et seq. of the Code of Virginia), and the Rehabilitation Act (20 USC§ § 794).
- Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Environmental Modifications. DME and Supplies information can be found on the DMAS Web Portal by accessing the *DME Provider Manual, Appendix B* at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

EM Provider Documentation Requirements

1. Supporting documentation must demonstrate the medical need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the timeframe during which the service is to be provided. This includes a separate written notation of the evaluation, design, labor, and supplies or materials (or both). The supporting documentation and plan of care must include documentation of the reason that a Rehabilitation Engineer is needed, if one is to be involved;
2. Documentation of the date services are rendered and the amount of services and supplies;
3. Any other relevant information regarding the modification;
4. Documentation of the completion of the modification and written receipt and satisfaction of the individual/primary caregiver with the service provided;
5. Instructions are to be provided to the individual/primary caregiver regarding warranty coverage, repairs, maintenance and complaint resolution;
6. The EM provider will ensure that all work and products are delivered, installed and in good working order prior to the end of the plan of care year and prior to billing DMAS;

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7. The date of service on the provider claim must be within the service authorization approval dates, which may be prior to the completion date as long as the work commenced during the service authorization approval dates; and
8. The service authorization will not be modified to accommodate installation delays. All requests for cost changes (either increases or decreases) must be submitted to the DMAS designated Service Authorization Contractor for revision and must include justification and supporting documentation of medical needs.

ASSISTIVE TECHNOLOGY

Service Definition

Assistive Technology (AT) services are specialized medical equipment and supplies, including those devices, controls, or appliances, that are medically necessary to enable individuals to increase their ability to perform ADLs or to perceive, control or communicate with the environment in which they live. This service includes ancillary supplies and equipment medically necessary for the proper functioning of such items. AT cannot be provided as a “stand alone” waiver service. AT devices are expected to be portable.

Medically necessary includes those services or specialized medical equipment or supplies that are not covered for reimbursement under the *State Plan for Medical Assistance* that are reasonable, proper, and necessary for the treatment of an illness, injury or deficit.

Criteria

In order to be eligible for these services, the individual must have a demonstrated need for AT equipment for remedial or direct medical benefit primarily in the individual’s primary residence to specifically serve to improve the individual’s personal functioning.

Collaboration

An independent, evaluation shall be obtained from qualified professionals who are knowledgeable of the recommended item for each AT request prior to approval by the Srv Auth contractor. All evaluations must be signed by the qualified professional. The professional evaluation includes the trial period of time for the individual to use the device and documentation of any follow up training provided for the recommended items. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists. A prescription alone shall not meet the standard of an evaluation.

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Examples of Assistive Technology Devices (not a comprehensive list)	Professional Evaluation Required
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces for hands, arms, feet, legs, etc.	Physical Therapist, Physician or Orthotist
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist
Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occupational Therapist; depending on the device or equipment
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist, or Behavioral Consultant

Items such as furniture shall not be approved if they are of general utility and are not of direct medical benefit.

The AT provider's quote must be compatible with the evaluation completed by the qualified professional.

The provider and the waiver individual may collaborate with multiple providers in order to complete a request for AT, for example:

1. A Physical Therapist, Speech Therapist or Occupational Therapist may be accessed to evaluate the needs for AT; and/or
2. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's AT needs. The Rehabilitation Engineer may actually design and personally complete the AT, if needed.

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For example, a Rehabilitation Engineer might be required if:

- The AT involves combinations of systems (which may include EM), which are not designed to go together; or
- An existing AT device must be modified or a specialized AT device must be designed and fabricated.

Collaborative funding is allowed for Medicaid covered services; however, due to the Federal rules, the provider would need to break down the parts. For the parts funded with Medicaid dollars, the provider must accept payment as payment in full. The provider will need to delineate which parts are Medicaid funded and which are private pay or another funding source, e.g., DARS, Assistive Loan Fund Authority, church or other private funding, etc.

Service Units and Service Limitations

- The service unit is always one, for the total cost of all AT requested for a specific timeframe. The service unit is the total cost of the item and any supplies, or hourly Rehabilitation Engineering costs.
- The maximum Medicaid-funded expenditure per individual for all AT covered procedure codes combined shall be \$5,000 per individual per SFY (State Fiscal Year – July 1 to June 30). Unexpended portions of the maximum amount shall not be carried over from one SFY to the next.
- AT shall be covered in the least expensive, most cost-effective manner. An AT provider's written cost estimate for labor and materials for AT must be submitted to the Srv Auth contractor. AT shall be provided primarily in the individual's home or community setting.
- Each item shall be authorized by the Srv Auth contractor prior to providing the service and cannot be authorized retroactively. The service authorization will not be modified to accommodate delays in product deliveries. In such situations, new service authorizations must be sought by the provider.
- Computer software purchased for an individual must be owned by the individual and accessible by the individual/caregiver to make changes, download updates, etc.
- All products must be delivered, demonstrated, installed and in working order prior to submitting any claim to Medicaid. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as the initiation of services commenced during the approved dates.

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- When two or more individuals receiving waiver services live in the same home, the AT shall be shared to the extent practicable consistent with the type of AT.

Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be authorized through the DMAS Srv Auth Contractor if more than five (5) visits have been provided to the individual. Visits are individual-specific, not provider-specific.

- AT shall not be available to waiver individuals younger than 21 years of age. AT for these individuals shall be accessed through the EPSDT benefit.

Service Exclusions

- AT is not covered for purposes of convenience for the caregiver or for restraint of the waiver individual, or for recreation, leisure, diversional purposes, or for an outlet for behavioral supports, or for educational purposes. Such items include, but are not limited to, swing sets, playhouses, bowling balls, tricycles/bicycles, trampolines, television sets, video equipment/games, computer games, playing cards, printers, scanners, musical, educational, vocational software or hardware, sporting equipment, exercise equipment, etc. are not covered.
- Providers that supply AT for the individual may not perform the professional evaluation, or write specifications for that individual.
- AT equipment and supplies shall not be rented but shall be purchased through an AT provider.
- DMAS does not repurchase items paid for with AT funds unless those items have specific timeframes or usefulness (i.e. computer - 5 years).
- DMAS does not pay for duplicate items such as software and later updates to original purchases. This is considered carry over from one year to the next.
- Only the actual cost of material and labor is reimbursed. There shall be no additional markup. Shipping, freight and delivery are not billable to DMAS or to the waiver individual, as such charges are considered non-covered.
- Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Assistive Technology. DME and Supplies information can be found on the DMAS Web Portal by accessing the *DME Provider Manual, Appendix B*. at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

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Provider Documentation Requirements

The document requirements are as follows:

1. The evaluation must be completed by the independent professional consultant;

Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the timeframe during which the service is to be provided. This includes separate notations of design, labor, supplies, and materials. The supporting documentation must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be involved if a need for such expertise is documented;

2. Written documentation regarding the process and results of ensuring that the item is not covered by the *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies and that it is not available from a DME provider when purchased elsewhere;
3. Documentation of the date services are rendered and the amount of service needed; other relevant information regarding the device or modification;
4. Documentation of the individual/caregiver's receipt of and satisfaction with the AT provided as well as any training provided to the individual/primary caregiver on the usage of the AT;
5. The date of service on the claim must be within the service authorization approval dates, which may be prior to the delivery date as long as services commence during the approved dates;
6. The AT provider is required to deliver and ensure the individual is trained to use the equipment prior to the end of the plan of care year and provide instructions regarding any warranty, repairs, complaints, or servicing that may be needed;
7. The AT provider will ensure that all work and products are delivered, installed and in good working order prior to the end of the plan of care year and prior to billing DMAS;
8. Any request for a change in cost (either an increase or a decrease) requires justification and supporting documentation of medical need and authorization by the SA contractor; and

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9. The AT provider must receive a copy of the professional evaluation in order to purchase the items recommended by the professional. If a change is necessary, then the provider must notify the assessor to ensure the changed items meet the individual's needs.

TRANSITION SERVICES

Service Definition

Transition Services are a means of providing for set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Individuals may receive Transition Services for up to nine (9) months through the CCC Plus waiver. Individuals who leave a qualified institution prior to enrolling in CCC Plus waiver, but demonstrate a need for Transition Services have 30 days to apply for the service post transition.

Transition Services shall be service authorized for nine (9) months. If the waiver individual chooses consumer directed services, the DMAS designated fiscal employer agent (F/EA) shall manage the reimbursement for the transition services. If the waiver individual chooses agency directed services, the health plan shall manage the reimbursement to the agency or provider for the transition services.

All individuals using the CCC Plus waiver must have the transition services included on a person-centered transition service plan prior to seeking service authorization from the health plan.

Criteria

Transition services are furnished only to the extent that:

- they are reasonable and necessary as determined through the transition service plan development process,
- they are clearly identified in the transition service plan,
- the person is unable to meet such expenses, and
- the goods/services cannot be obtained from another source.

This service does not include services or items that are covered under other waiver services, or state plan options, or by other providers.

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Service Units and Service Limitations

Services are available for one transition per waiver individual per lifetime limit and must be expended within nine (9) months from the date of authorization. The funds shall not be available to the individual after that period of time.

The total cost of these services shall not exceed \$5,000 per person per lifetime limit, coverage of transition costs to residents of Nursing Facilities, Long Stay Hospitals, ICFs/IID (Intermediate Care Facilities for Individuals with Intellectual Disabilities), PRTFs (Psychiatric Residential Treatment Facilities) or IMDs (Institute for Mental Disease) who are Medicaid participants and are able to return to the community.

Transition Services may be requested within 30 days after a transition. If not requested within that timeframe, the individual will not be considered for transition services.

The provider shall work closely with the individual to assure that all costs are reasonable and necessary for transitioning from the institution to the home-and-community-based setting.

Allowable costs include, but are not limited to:

- Security deposits that are required to obtain a lease on an house, condo, apartment or other residence; Essential household furnishings and appliances required to occupy and use a community domicile, for example furniture, window coverings, food preparation items, and bed/bath linens;
- Connection or set-up fees or deposits for utility or services access, such as telephone, electricity, heating and water;
- Services necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;
- Moving expenses;
- Needed clothing items; and
- Fees to obtain a copy of a birth certificate, photo identification card, or driver's license.

Non-allowable costs include, but are not limited to:

- Re-occurring charges such as monthly rental or mortgage expenses;
- Food;
- Regular utility charges;
- Household items that are intended for decoration, diversional or recreational purposes; and
- Services or items that are covered under other waiver services such as chore, homemaker, environmental modifications and adaptations, or specialized supplies and equipment.

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DISCONTINUANCE OR CHANGE IN SERVICES BY THE PROVIDER

Advance Notice required for Personal Care/Respite/SF/ADHC/PERS/PDN

There are various financial, social, and health factors that might cause a provider to discontinue, increase, or decrease services to a Medicaid individual. The provider must make adjustments to services as indicated by any change in the individual's needs or situation. The provider must give the individual or family ten (10) calendar days written notification plus three days for mailing of any decision to discontinue or to change the amount of services received (unless the individual requests a date which is less than ten (10) calendar days and the provider documents the individual's request).

The provider may discontinue services if the individual fails to pay the required patient pay amount that is due. If services are discontinued by the provider, this notice must **not** contain appeal rights since the individual has not been terminated from Medicaid services.

Decrease in Hours

If the RN Supervisor/SF has determined that a decrease in hours of service is warranted, the RN Supervisor/SF must discuss the decrease in hours with the individual or family during a home visit and document the visit and conversation in the individual's record. If there is to be a decrease in hours, the provider must develop a new Plan of Care and notify the individual, the caregiver, and submit a request for the decrease in hours to the srv auth contractor. The provider/SF must state in writing the specific reasons for the decrease, the new number of hours to be provided per week, and the effective date of the decrease in hours. The provider/SF must give the individual a copy of the new DMAS-97A/B. The srv auth contractor must also receive the new DMAS-97A/B,

If the individual requests a decrease in hours by telephone, the RN Supervisor/SF is not required to make an extra visit to the individual's home. The provider/SF will send a letter confirming the individual's request, the new number of hours, the new DMAS-97 A/B, and the effective date of the change. The new DMAS-97 A/B must be signed by the individual at the next visit.

If the individual disagrees with the decrease or the new Plan of Care, the effective date of the decrease shall be ten (10) calendar days from the notification date. The provider must develop the Plan of Care based on the assessment, but request from the srv auth contractor the actual number of hours that the individual/caregiver wants. The request to the srv auth contractor must clearly state that the individual/caregiver does not agree with the decrease. The srv auth contractor will review all of the information submitted. If unable to authorize what the individual/caregiver requests, the srv auth contractor will process the change request as a partial denial, and appeal rights will be offered in the letter automatically generated through the MMIS system.

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The individual may file an appeal with DMAS, in accordance with *12 VAC 30-110-100*.

Increase in Hours

The provider/SF is able to establish the amount of service in the Plan of Care, which is appropriate to meet the individual's needs as long as the maximum number of hours per week for that individual's level of care is not exceeded. (Under no circumstances can the individual receive more hours of care than his or her level of care allows without prior approval from the srv auth contractor).

The provider/SF must send a request to the srv auth contractor to authorize the increase if a change in the individual's condition indicates that either (i) supervision needs to be added to the Plan of Care or (ii) the individual's level of care has changed and an increase to the Plan of Care is needed for more than the amount allowed according to the individual's current level of care. This contact must be documented in the individual's record with the date and time of the call, to whom the RN Supervisor/SF spoke with, the requested information, and the outcome of the call. The updated DMAS-97 A/B and any other documentation necessary to justify the need for and use of hours may be requested by the srv auth contractor.

The srv auth contractor will transmit authorizations or denials to the MMIS. Once the entry has been made, the provider/SF and individual will receive a computer-generated letter notifying them of the decision and providing appeal rights if a denial or partial approval is issued. Individuals have the right to appeal any adverse action taken by the srv auth contractor. A copy of this letter must be maintained in the individual's record.

Transfer of Cases

When a SF or Personal Care Agency chooses to end services or when an individual chooses to change providers for a service, the prior SF/agency should supply the new SF/agency provider with a copy of the last Plan of Care, a copy of the discharge 225, and a copy of the screening (if available). The new provider should request this documentation from the prior SF/agency provider to assist the new provider in developing an appropriate Plan of Care for the individual.

For a transfer admission, the new provider/SF must submit a request to the srv auth contractor and complete the required questionnaire. The information from the DMAS-97A/B or DMAS-301, the DMAS-99 and the DMAS-100 (if the Plan of Care includes supervision time) will be needed when completing the questionnaire. **The new provider must complete a new assessment and Plan of Care for authorization of services.** If the previous provider/SF has not discharged the individual through the srv auth contractor, the new provider/SF must answer the questions on the questionnaire regarding transfers using the information found on the discharge DMAS-225, or a transferring letter from the previous provider indicating the last billable date of service.

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NOTE: If there has been a lapse in time between services, the provider is responsible for ensuring that the screening is still valid, as specified in the Medicaid Long Term Services and Supports (LTSS) Screening Provider Manual.

If the individual's previous Plan of Care included supervision or was for hours over the individual's level of care and the new (receiving) provider/SF has evaluated and found that these same hours are needed and criteria are met for the supervision or hours over the level of care, the new provider should verify that these hours were previously approved.

In transfer situations, supervision and hours over the LOC cap may be approved to the start of care date when the request is submitted within 10 business days of the start of care. Supervision and hours over the LOC maximum will only be authorized by the service authorization contractor when the new provider/SF provide documentation showing criteria are met and with appropriate documentation/justification for the hours included in the plan of care.

If the new provider/SF's Plan of Care is a decrease in hours from what the individual was previously receiving, the provider/SF must send the individual a decrease notification letter. These decreased hours may be implemented if the individual is in agreement with the new hours and Plan of Care. If the individual disagrees with the decrease and the new Plan of Care, the effective date of the decrease shall be ten (10) calendar days from the notification date. The provider must develop the plan of care based on the assessment, but request from the srv auth contractor the actual number of hours that the individual/caregiver wants. The request to the srv auth contractor must clearly state that the individual/caregiver does not agree with the decrease. The srv auth contractor will review all of the information submitted. If unable to authorize what the individual/caregiver requests, the srv auth contractor will process the change request as a partial denial, and appeal rights will be offered in the letter automatically generated through the MMIS system.

The individual may file an appeal with DMAS, in accordance with *12 VAC 30-110-100*.

Disenrollment from Consumer-Directed Services

There may be instances in which a waiver individual must be disenrolled from consumer-directed services, either voluntarily or involuntarily. The following situations may be cause to remove an individual from consumer-directed services:

- It is determined that the waiver individual cannot complete the duties of the EOR and no one else is able to assume this role;

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- The waiver individual has medication or skilled nursing needs or has medical or behavioral conditions that cannot be met through CD services or other services;
- The waiver individual, or EOR, as appropriate, is consistently unable to retain or manage the attendant as may be demonstrated by, but not necessarily limited to, a pattern of serious discrepancies with the attendant's work shift entries or non-compliance with CD EOR requirements.

Under these circumstances, the Services Facilitator must offer agency-directed services as the alternative to the waiver individual and provide the individual the freedom of choice to select the personal care agency.

In situations where the attendant's work shift entry discrepancies are known, the services facilitator should assist the waiver individual's transfer to agency-directed services by doing the following:

1. Verify that training has been provided to the waiver individual or EOR, as appropriate;
2. Document in the waiver individual's record the conditions creating the necessity for the individual's disenrollment and actions taken by the services facilitator;
3. Discuss with the waiver individual and/or EOR, as appropriate, the option of agency-directed services and the actions needed to arrange for such services as well as offer the individual the choice of potential agency providers;
4. Provide written notice to the waiver individual of the right to appeal such involuntary termination of consumer direction. The written notices must give at least 10 calendar days plus 3 for mailing prior to the effective date of this termination. In cases when the individual's or provider personnel's health, safety, or welfare may be in jeopardy, the 10 day notice does not apply.

PDN Transfer

The PDN provider must transfer an individual's care to another PDN agency whenever the provider is no longer able to sufficiently staff the individual's case or the individual requests a transfer to another provider of their choice.

- The transferring skilled PDN provider is instructed to contact DMAS to inform them of the need to transfer the individual, the provider chosen to accept the transfer and the effective date of the transfer.
- The transferring skilled PDN provider must send to the accepting skilled PDN provider and DMAS:

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1. The last date of service to be rendered by the transferring provider and the reason for the transfer;
2. A copy of the current POC/CMS-485;
3. The individual's waiver PDN Needs Assessment or the LTSS Screening packet including the DMAS 96, 97, UAI, and DMAS-108 with the individual's PDN admission date to the waiver;
4. The most recent Waiver PDN Monthly Supervisory Visit (DMAS-103) form; and
5. The DMAS-225 communication form sent to DMAS and DSS.

Note: The accepting provider is responsible for ensuring the above information is received and seeking approval from DMAS prior to the initiation of services. Once services start, the accepting provider must send to DMAS the RN Initial Home Assessment form (DMAS-116) and a copy of their initial POC/CMS-485.

Advance Notice Not Required

CCC Plus waiver services may be discontinued without prior notice, if the provider's staff or SF is in immediate danger, or the individual requests immediate discontinuation of services, or the provider does not have staff available to render services and is unable to secure a substitute aide or transfer services. However, the provider/SF must send a letter to the individual indicating that the discontinuation of waiver services and the effective date. A copy of this letter must go to the local department of social services, and Adult Protective Services, if applicable. The discharge request must be submitted to the srv auth contractor. A copy must also be kept in the individual's record.

If the provider does not have staff, the provider must attempt to transfer services to another provider agency. If the individual has adequate back-up support and requests that the provider not transfer the services, the individual must be informed of progress or lack of progress and alternatives. This must be documented in the individual's record. The provider must inform the individual that, if services are not received for 30 consecutive days, continued waiver eligibility will be affected.

Transitioning to Developmental Disability (DD) Waiver for Individuals under Managed Care

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When a managed care enrolled member is transitioning from the CCC Plus Waiver to a DD Waiver, DD waiver enrollment, service authorizations, and services cannot begin earlier than the first day of the month after the month in which the CCC Plus Waiver service authorization ended. For example, if an individual is enrolled in the CCC Plus Waiver and is assigned a DD Waiver slot on December 10th, the earliest that any DD Waiver services may be authorized to begin is January 1st. The CCC Plus Waiver service authorization will automatically end based on the effective date of the DD Waiver enrollment.

For individuals transitioning from the CCC Plus Waiver to a Community Living (CL) or Family and Individual Supports (FIS) Waiver, the same number of personal care hours authorized by the MCO for an individual enrolled in the CCC Plus Waiver will be honored for 30 days. To ensure a seamless transition and mitigate service interruption, providers should follow the continuity of care service authorization process as follows:

1. The SF/agency should expect contact from the Support Coordinator for the individual's DD Waiver services. The SF/agency should make sure the waiver individual has consented to allow an exchange of information with the Support Coordinator.
2. The SF/agency uploads the most recent Plan of Care (DMAS-97A/B) into WaMS. In the justification box in WaMS, the SF/agency will enter "continuity of care service authorization request". If the Support Coordinator finds the hours on the Plan of Care do not match those authorized by the MCO, the SF/agency must submit a revised Plan of Care that reflects the hours authorized by the MCO.
3. The Services Facilitator/Agency provider completes and submits to the Department of Behavioral Health and Disability Services (DBHDS) all required assessments and documentation for CL or FIS Waiver service authorization of personal care services by the 20th of the month that the continuity of care service authorization is in effect. Any delay on the part of the provider shall result in the service authorization start date being the date the request was submitted.
4. For consumer-directed services, the Services Facilitator must submit the Fiscal Agent Request Form to Consumer Direct Care Network and initiate the change in Fiscal/Employer Agent, if applicable, and the change from CCC Plus Waiver services to DD Waiver services.

For questions regarding this procedure, contact the Division of High Needs Supports at DDwaiver@dmass.virginia.gov.

INDIVIDUAL HEALTH, WELFARE AND SAFETY ISSUES

If the provider/SF becomes aware that the services being provided and the individual's current support system may not adequately provide for the individual's safety, the provider/SF should

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immediately determine whether the individual's current status represents a potential risk or an actual threat to his or her health, welfare or safety.

A potential risk is identified as deterioration in either the individual's condition or environment, or both, which, in the absence of additional support, could result in harm or injury to the individual.

An actual threat is the presence of harm or injury to the individual which can be attributed to the individual's deterioration and lack of adequate support (e.g., the individual becomes anemic, malnourished, or dehydrated due to the inability to obtain food and water; the individual develops decubitus due to lying in urine or feces, etc.).

To determine whether an actual threat may exist, the provider should consider the following:

1. Is the individual capable of calling for help when needed?
2. Is there a support system available for the individual to call?
3. Can conditions be arranged for the individual to care for basic needs when the support system is absent?
4. Is the individual medically at risk when left alone?
5. Has some harm or injury to the individual been reported?
6. Does the individual express fear or concern for his/her welfare?

If answers to any of the above listed concerns indicate a potential risk, the provider/SF is required as a mandated reporter by State Law to report to Adult Protective Services (APS)/Child Protective Services (CPS) at first suspicion.

When reviewing service authorization requests, when a real threat to the individual's health, safety, and/or welfare exists, the srv auth contractor will attempt to assess whether additional services can be obtained to maintain the individual in a home environment. If continued maintenance in the home is not possible, the contractor will initiate procedures to terminate services and advise the provider/SF or the individual that nursing facility services should be considered. The provider/SF shall report the situation to APS/CPS. For the provider's/SF's protection, a letter from the provider should follow up a telephone call to APS/CPS. Waiver services may be discontinued if a safe Plan of Care cannot be developed.

SUSPECTED ABUSE OR NEGLECT

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If the provider suspects that a CCC Plus Waiver individual is being abused, neglected, or exploited, or is at risk for abuse, neglect or exploitation, Virginia law (§§ 63.2-1606 and 63.2-1509 *Code of Virginia*) mandates that the party having knowledge or suspicion of the abuse, neglect, and/or exploitation, immediately make a report to either the LDSS where the individual resides or to the toll-free, 24-hour hotlines:

APS: 1-888-83 ADULT (1-888-832-3858)

CPS: 1-800-552-7096 (out of state); 804-786-8536 (in- state).

Local departments of social services are responsible for the investigation of alleged adult abuse, neglect, and exploitation and alleged child abuse and neglect. The contact with the local departments may be made anonymously, but the provider record must note the alleged abuse, neglect, or exploitation and state that the appropriate report has been made. The provider/SF must also report the suspicions to DMAS.

RELATION TO OTHER MEDICAID-FUNDED HOME CARE SERVICES

Home Health

Home health services are provided by a certified home health agency on a part-time or intermittent basis to an individual in their place of residence. An individual's place of residence does not include a hospital or nursing facility. Home health services are intended to provide skilled intervention with an emphasis on individual/caregiver teaching. For additional information and covered home health services, refer to the Department of Medical Assistance Services Home Health Provider Manual, which can be found on the Medicaid web portal located at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

Hospice Care

Hospice is an autonomous, centrally administered, medically-directed program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill individual and the family.

It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic challenges, which are experienced during the final stages of illness and during bereavement. The goal is to maintain the individual at home for as long as possible while providing the best care available to the individual thereby avoiding institutionalization. For additional information and covered hospice services, refer to the Department of Medical Assistance Services Hospice Provider Manual found on the Medicaid web portal located at: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library>.

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Simultaneous Provision of CCC Plus Waiver Services and Hospice Services

The following information is applicable regardless of whether the hospice receives reimbursement from Medicare or Medicaid for the services covered under the hospice benefit. Hospice enrollment does not limit the waiver services an individual may receive. Waiver services must be authorized by the srv auth contractor. The waiver services provider/SF is required to coordinate services with the hospice provider for those individuals also enrolled in a hospice benefit.

REFUSAL OF SERVICES BY THE INDIVIDUAL

Individuals have the right to refuse services. This refusal must be documented in the individual record. If all services for the day are refused, the aide should contact the provider agency, leave the home and document the early departure time. If services are refused frequently, a reduction in care hours may be warranted (see “Decrease in Hours” in this chapter). This refusal must be documented by the provider in the individual’s record and an evaluation should be conducted, and the service-authorization contractor staff should be contacted, if appropriate.

The provider may not bill Medicaid for the individual for any time services are scheduled, but the aide/attendant is not able to provide care (e.g., the aide arrives and the individual is not home).

CHANGE OF RESIDENCE

If an individual’s residence changes, the provider must record this change in the individual’s record and notify the LDSS immediately and in writing (using the DMAS-225).

INDIVIDUALS WITH COMMUNICABLE DISEASES

Current information regarding the transmission of Acquired Immune Deficiency Syndrome (AIDS) and other similar communicable diseases indicates that these diseases are not transmitted through casual contact, and isolation techniques or procedures are not required for providing care to these individuals in their homes.

Certain routine hygienic precautions designed to prevent the spread of all communicable diseases, including blood borne infections, should be taken by all providers when rendering care to any individual, regardless of his/her known medical condition. These precautions should include care in handling sharp objects such as needles, the wearing of disposable gloves when one could become exposed to blood or other body fluids, and scrupulous hand washing before and after caring for each individual.

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Providers are prohibited from discriminating against individuals who have been diagnosed as having Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) and other communicable diseases.

INDIVIDUALS WITH MENTAL ILLNESS, INTELLECTUAL DISABILITIES, DEVELOPMENTAL DISABILITIES, OR RELATED CONDITIONS APPROVED FOR SERVICES

Federal waiver programs are designed to serve a specific targeted population. The CCC Plus Waiver can only serve individuals who are at risk of nursing facility placement and meet all eligibility requirements for the waiver. Individuals who qualify for the CCC Plus waiver may also be on waiting lists for other waivers. Refer to the DMAS web site for more information on waivers for individuals with developmental or intellectual disabilities.